
Journal of Medicine and Medical Research
Vol. 4(2): 7-26, May, 2016
ISSN: 2350-1502

www.resjournals.org/JMMR

The South African Government's Proposed Implementation of the National Health Insurance Plan (NHI): A Disaster Waiting to Happen

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Abstract

The paper looks at the proposed National Health Insurance Plan, in terms of its implementation and exorbitant costs. It poses the question as to whether South Africa is ready to implement this necessary plan in terms of universal health coverage, after years of apartheid oppression. It argues that the NHI squeeze is coming and that the plan will "not survive the legal test."In reality there is no quick fix for the NHI. The paper places in perspective all the nuts and bolts of the NHI. The country is therefore watching the funding proposals keenly. It will further argue that the plan is a sketchy grand public health vision. It is therefore imperative that the government invests in health infrastructure development. In other words the public health system is in disarray after 21 years of democracy and that the nation has lost confidence in the government and its health department. They have to first deal with the issues that permeate the failure of the public preventive health system, which was devolved to the district levels of the public healthcare system. Universal health coverage is important and vital to South Africa but perhaps, it is not the time to implement the NHI due to various reasons which will be argued in this paper.

Keywords: Healthcare, National Health Care System, Private and Public Health Care, Implementation, Costs, Primary Health Care, Preventive Medicine

INTRODUCTION

There has to be a realization by the government of South Africa that politics is the art of the possible and economics is focused on the effective utilization of scarce resources, and therefore all governments should be concerned with the political economy of health care management and of public health issues (Karodia, 2013: 20). Advances in preventive medicine or public health depend on the prior allocation of scarce economic resources, primarily through actions in the political arena. There has to be a realization on the other hand that, there is nothing easy about eliciting a favourable response through the political process to attract the required economic resources even in the face of the probability of significant health gains being achieved. By the same token governments in general place scant reference to the issues that permeate healthcare initiatives without the prior consideration of the question of choices which must be understood in terms of understanding the concept of the political economy and, often make the wrong choices that burden the tax paying public. "No political leadership, even the most securely ensconced autocracy, will enter upon new policies or programmes that are a direct challenge to the status quo without strong reasons. Even if the benefits appear substantial, the leadership might still hesitate to start innovations on the ground that the existing political equilibrium should not be jeopardized" (Last, 1980). Under the present government of South Africa, these tenets and principles are paid scat reference to because the ruling government has become a law unto itself. This fundamental tenet according to Karodia (2015:10)"has been overtly compromised by the President of South Africa, Jacob Zuma and his Cabinet with the aid and sanction of the ruling African National Congress, when one considers the firing of a competent Minister of Finance,

which saw the South African economy bleeding to a loss of R184 billion in four hours; the loss in investor confidence; the high uncontrollable public wage bill (which now stands at nearly 50 percent of Gross Domestic Product (GDP); the allocation of top jobs to incompetent and so - called untrained comrades of the revolution and members of the ANC; escalating electricity tariffs and the threat of load shedding; the clandestine acceptance of the proposed nuclear deal without costing the project, at a cost of over R1.4 trillion and, will surely escalate once approved; the Rand plummeting to levels never seen before in the history of South Africa against all the major currencies of the world (nearly R17 to the dollar, nearly R24 to the pound sterling, and nearly R18 to the Euro and R1.40 to the Botswana Pula; the electricity crisis which requires trillions of Rands to remedy; the cry for free higher education by students that will run into billions of Rands; the water crisis exacerbated by poor water infrastructure that will require more than R800 billion to repair over a ten year period, the pangs of a severe drought confronting the country which has virtually destroyed agriculture and, is threatening food security with the reliance on imports of staples; high inflation and interest rates, with the probability of increasing Value Added Tax (VAT) and increased taxes that will have to be levied on a very small tax base that will greet 2016, and compromise the population; the high debt that has to be serviced by the fiscus; the possibility of approaching the International Monetary Fund (IMF) for a bailout and surrendering the South African economy to structural adjustment programmes of the IMF; a likely scenario that South Africa will enter a recession given that economic growth for 2016 will be only in the region of 0.8 percent;increased civil unrest and protests and now the funding of the NHI at a cost of trillions of Rands over 14 years; the propensity of government spending without checks and balances; continued uncontrollable looting and corruption involved in state funds through favoured tenders and other unnecessary activities, running into billions by the ruling elite; the building of the Presidents controversial homestead at the cost of some R246 million, the enlarged Cabinet; the downgrade of the South African economy by rating agencies to almost 'junk' status. Yet the South African government amidst many other serious issues believes that, there is nothing wrong. The country is on the verge of being declared a failed state and a 'banana republic'." Nothing seems to trouble the government as poverty increases, unemployment sores to unprecedented levels (over 35 to 45 percent, depending on the source referenced) and inequality is widening, as the rich and the ruling elite become richer whilst the poor remain in the doldrums and must reconcile to a damaged future which will affect the generations to come. Cry the Beloved Country.

There is a ground for immense caution: most innovations require investments that can be made only to the extent that the government is able to extract from the tax – paying public some part of their income or capital. But all people who live close to the levels of subsistence in South Africa, which makes up the majority, as well as those who are affluent citizens are resistant to transferring their money to the state" (Regent MBA Healthcare Module, 2013). This is precisely what is happening in South Africa and government is now ruling with stealth. There are competing demands in terms of social issues that the government of South Africa is not considering in terms of governance and is slowly but surely destroying the country. If this form of governance continues South Africa could reach a stage of insurrectionary proportions, very soon. The government of South Africa must realize that it does not really know much about the direct, much less the indirect, consequences of various types of societal interventions in order to consolidate democracy and make the country a winning nation. As things stand currently, it is a losing nation and, sliding into the abyss of complete ruin under the present ANC led government.

Methodology

The paper will use salient newspaper articles in the main to articulate the narrative. By the same token a number of issues will be discussed which is pertinent to the discussion by the use of applicable textbooks. The authors will also rely on their critical analysis and observations. No specific and classical research methodology will be used in this narrative. In no way will the methodology dilute the thrust and outcomes of the paper

Aim of the Paper

The central aim of the paper is to discuss whether the NHI as it stands is an achievable proposition, in the short and medium term, given the economic and fiscal crisis that confronts South Africa. It will argue that there are other salient considerations that must be taken into consideration before than NHI can be implemented given South Africa's economic woes and the exorbitant costs to implement a utopian plan.

Objectives of the Paper

There are no specific objectives that the paper will talk to but, in so doing the following objectives must be realized:

To criticize the plan objectively.
To concientize the reader about the ambitious plan which is currently not implementable as stated above.
To conduct a brief literature review on issues defined in this paper, in order to enhance the discussion and narrative.
To place in perspective some issues of the Public Health System of South Africa on the basis that these programmes are vitally important to primary health services of the Republic within its stated health policy and its district health system, post democracy in 1994.
To outline very briefly the issue of health infrastructure development which is vital for the delivery of quality health services, which is currently in disarray after 21 years of democracy.
To underscore the fact that universal health coverage is an imperative that must be implemented and thoroughly explored by the democratic government, in order to provide quality health care to the poor and the South African population in general.
To outline some comparisons in respect of South Africa's public health system versus the private health system.
Further, to introduce certain other salient health and political aspects, pertinent to the narrative and the subject matter.
To outlinethe legal considerations not considered by the White Paper on the NHI.

LITERATURE REVIEW

Levels of Healthcare Service and the Primary Healthcare Approach

Healthcare service levels can be categorized as follows according to the University of Cape Town (2005):
"Primary Level – basic curative and preventive services; generally outpatient basis; general practitioners and Primary Healthcare nurses (PHC), often deliver this level of care.
Secondary Level – mostly curative services; generally inpatient services; most often specialists – led teams deliver this level of care.
Tertiary Level – highly specialized level of care; advanced technology and expertise; referral patients from secondary level.
Quaternary Level – usually academic and central hospitals; mainly used for advanced curative care."
In South Africa emphasis is placed on the primary level of healthcare services, because the country uses the primary healthcare approach within its health system for the delivery of healthcare. "On the 12thSeptember 1978, the international Conference on Primary Health Care was held ay Alma – Ata in the former Russia (USSR). The conference reaffirmed the WHO's definition of health and acknowledged the gross inequalities of healthcare in developed and developing countries" (WHO, 1978). Primary Health Care was defined at the Alma Ata Declaration as:

"Essential healthcare based on practical, scientifically sound and socially acceptable methods and technology made universally accessible to individuals and families in the community through their full participation and at a cost that the community and country can afford to maintain at every stage of their development in the spirit of self – reliance and self – determination." It forms an integral part of South Africa's health system post democracy since 1994 and therefore, its central function and main focus, is the overall social and economic development of the community. It is the first level of contact of individuals, the family and the community with the national health system, which is currently in disarray and defeats the purpose of universal health coverage which is the main thrust of the government of South Africa. Given the all - embracing reality of a dysfunctional public health sector,the situation as it stands can therefore not accommodate the implementation of the NHI. The idea is indeed commendable in that, the government is desirous of bringing healthcare as close as possible to where people live and work, and this therefore by implication "constitutes the first element of a continuing health care process" (WHO, 1978). It is an indictment of government policy 21 years down the road to South African democracy.

According to the WHO (1978) the eight elements of Primary Health Care are:
- "Education concerning prevailing health problems and the methods of preventing and controlling them." The South African public health sector has generally failed to do so.
- "Promotion of food supply and proper nutrition." In this regard the safety network for the provision of food has collapsed and South Africa therefore has to rely on the importing of food staples. The increasing inequality and poverty that permeates South African society and the majority living off social grants negates this basic principal. Proper nutrition is a pipe dream as food prices together with inflation and the poor economic climate testifies to a country in shambles and little hope for the poor.

- "An adequate supply of safe water and basic sanitation." South Africa is seething with a protracted drought, dams are empty, there are water cuts in many areas and the country requires over R800 billion over the next 10 years, to rectify the water infrastructure problem. Basic sanitation is in dire straits in schools and the rural areas of the country.
- "Maternal and child healthcare, including family planning." Although these programmes are an essential part of the Primary Health care system of the country, they have largely failed. (These issues will be discussed later within the paper).
- "Immunization against major infectious diseases." Progress in this regard has been muted and the country has a long way to go in this regard.
- "Prevention and control of locally endemic diseases." Some progress has been made in this regard, but the situation is exacerbated by illegal immigration into the country and the poor public health services that cannot cope with increased volumes of patients and the demands of the population.
- "Appropriate treatment of common diseases and injuries." With regards this issue the South African public health system generally does well but generally out – patient's facilities and public hospitals are overcrowded and there is a lack of the supply of medical doctors in the public health system.
- "Provision of essential drugs." This is an erratic situation because very often the South African public health system runs out of essential drugs and at times cannot even supply patients with proper prescribed medication and, this is a major problem. This is further exacerbated by the corruption that permeates the public health system.

It can therefore be seen that the Primary Health Care system is clearly compromised by the state in its endeavour to provide adequate public health care. It is therefore essential that the state remedies these issues and there can be no excuse for this after 21 years of democracy. It is therefore obvious that the administration of the public health system and its coordination at the current state it is in, cannot meet the aspirations and desire of the government of South Africa to implement the NHI, given its exorbitant costs, the poor state of the public health systemand an economy that is in ruins to render universal health coverage which is necessary and essential given the history of apartheid."Many industrialized and non – industrialized countries spend about 7 to 8 percent or more of their budgets in health care management but in South Africa high expenditure on health post 1994 has not seen the desired effects of health productivity and improvement, sustained outputs and increased accountability" (Regent MBA Module, 2013: 33). It can therefore be concluded that health looms high on the expenditure of most affluent and poor nations. It must therefore be an imperative in South Africa to redirect health expenditures from the curative to the preventive frontiers. What then are the factors influencing today's health care organizations: In this regard Jooste (2009:7) states and identifies these as follows:

- "The tremendous pressure to achieve greater productivity and efficiency through better expenditure control, maintaining universal accessibility, affordability and equitable distribution of healthcare resources.
- The World Health Organization (WHO) has recently declared tuberculosis a global emergency, and with HIV / AIDS pandemic, the role played by healthcare professionals and managers has become even more difficult; in contrast, the changing –
- Demographic patterns with people living longer and healthier lives in some countries, and the increasing population and varying life expectancies of people have fuelled this challenge.
- People are becoming more knowledgeable about health matters, and patients' rights also influences the demand placed on the health system of any country.
- Financing the health system is becoming more difficult, and this places a huge burden on the resources available and the mobility of the labour force. The length of stay in health institutions, levels of disease (acute), and chronic lead to far more work and greater responsibilities for healthcare professionals and managers"(Jooste, 2009:7).
- Healthcare statutory bodies such as the Health Professions Council of South Africa and the South African Nursing Council, patient's rights and government all serve as watchdogs to ensure the delivery of healthcare by strictly abiding to ethical codes of conduct. The ethical and moral dilemmas that healthcare professionals and managers are faced with daily, places additional strain on the system.
- The White paper on transformation of healthcare in South Africa (1997) "focuses on the decentralization of responsibility, accountability, power and authority to the lower levels of healthcare delivery. It also informs community involvement, decrease in bureaucratic practices and effective use of resources." (South African White Paper on Healthcare, 1997). These principles which are the backbone of the South Africanhealthcare system have in reality been compromised by government, health bureaucrats, politicians, including the general healthcare professionals that man the public health servicesof the country and, after 21 years of democracy South Africa's public healthcare system has nothing to show tangibly. In this regard, as things stand within the public health system, it can be categorically stated that the NHI is not currently implementable.

In those countries where the population lives close to the margin of subsistence – in much of Africa, including South Africa and Southeast Asia, governments can only make very modest gains in control of major health hazards and thus

works with a dysfunctional healthcare management system, especially from water and land – borne sources of infection. In this regard rapid growth of population, a shortfall of food supply, or an outbreak of another disease can roll back much or all of the progress earlier achieved. The import of this formulation in respect of the healthcare management system and the provision of healthcare and the advancement of public health are to establish close links that exist between advances in public health and family planning, education, economic productivity, and the strengthening of communal and governmental infrastructures" (Karodia, 2015). A country whose people live at or close to the margin of subsistence will find it exceedingly difficult to break the constraints that retard progress on the healthcare front. This is precisely what is happening in South Africa because there is a lack of vision on the part of the government even after 21 years of democracy and from the yoke of apartheid oppression. But even poor countries usually have a few centres where economic development is occurring, but sadly the pace of development in South Africa is occurring very slowly given the problems inherited from the past form of government; illiterate farm families do learn about contraceptive devices; and governments in the developing world, often with foreign aid and assistance, are able to mount some modest health improvement.

Karodia (2015) further points out that "It would be hard to find a country where stagnation exists in all fronts (Perhaps Zimbabwe currently, Somalia and South Sudan and the Democratic Republic of the Congo, including countries in war torn Syria, Iraq and Yemen, to name a few). All these countries are characterized by foreign interference and by sustained internal political turmoil, which invariably influence socio – economic and health progress." Two factors, however, operate to slow the progress that seriously handicapped counties can achieve (this does not pertain to South Africa and it cannot argue after 21 years of freedom and democracy that the greatest impediment currently is the legacy of apartheid; it is a question of poor governance). Because of the power and influence of the elite in South Africa and other countries, usually represented by those who fill the principal governmental positions in urban centres and the total neglect of the rural periphery of the country, the modest investments made on the health front are often concentrated on funneling new resources into therapeutic medicine, improving the local hospital, and starting a medical school and so on. The classic example or illustration of such action was seen in the former homelands of South Africa and other African countries. In this regard "the late Emperor Haile Selassie of Ethiopia built a 400 bedhospital in Addis Ababa, which preempted almost all the available doctors in the country" (Last, 1980: XX). The leadership of healthcare in any country "must be concerned with improving access to health and, in South Africa we see since democracy in 1994, a goal that the government has attempted to achieve and define but sadly, it has not been able to action this because, it has failed to do so, owing to corruption, poor accountability, untrained administrators, a poor work ethic by many health workers, the neglect of the rural periphery, grandiose government efforts, the lackof trained health personnel, the reliance upon expatriate health professionals, small health budgets and a lack of sound health policies coupled with poor implementation exacerbates the situation in many developing countries and particularly in South Africa" (Karodia, 2014).In this regard the Regent MBA Manual (2013) states that the involvement of the state in the healthcare System is premised on the following preconditions:

- "The state political system provides a framework for people's participation in policy formulation and implementation.
- The state dictates economic policy.
- Social welfare policies, such as those involving health and education, are often heavily dependent on state resources.
- Governments are centrally involved in health regulation and provision – from public health measures, for example, control of epidemics, to specific private sector regulations, for example, regulation of tariffs charged to clients.
- In most countries, governments are involved in the promotive, preventive, causative and rehabilitative services.
- There are Regulatory State Bodies of health professionals, for example, Health Professions Council of South Africa, South African Nursing Council and a host of others. Regulating the services is a function of these statutory bodies, with oversight from the state.
- Major decisions involving healthcare are multi – sectoral and require government oversight, such as the introduction of a new healthcare programme to manage tuberculosis or for that matter the implementation of the NHI, which must involve private and public healthcare providers, pharmaceuticals, companies, non – governmental organizations and so on.
- Governments may often be signatories to international; conventions that impact upon the health of the people and,
- Most governments are involved in health worker training."

Healthcare in South Africa

The Republic of South Africa is a non – racial democracy and obtained freedom from apartheid, in April of 1994. In this

sense it is a relatively young and emerging nation, grappling to come to terms with its past oppression by the white minority government and, by implication, it is confronted with mammoth inherited problems, in all spheres of development, including healthcare.It is a country of 1.2 million square kilometers and with a population of about 53 million (Recently or after 1994, large numbers of expatriates and illegal immigrants from all parts of the world including war torn African countries have entered the country. This adds tremendous pressure upon an already compromised and overburdened healthcare system). The country has increasingly become urbanized over the last few decades of the last century. Urbanization has intensified post 1994 and this rapid urbanization has been due to several factors / reasons. Since 1994 the healthcare system of South Africa, services the entire population. In this regard access to general healthcare and public health imperatives is guaranteed by the democratic Constitution and encapsulated by the Bill of Rights. This was not so under the racially based apartheid healthcare system prior to 1994. Given the above, the legacy of apartheid exemplifies the great disparity between the provision of healthcare services between the public and private healthcare systems and sectors. According to Karodia (2014 and the MBA Mancosa Manual, 2013) "The private sector serves the needs of about 20 percent of the population, especially the affluent, the emerging black middle – class and, a large number of public servants who have access by virtue of being subsidized by government for purposes of using private healthcare. The private sector offers excellent services at a price and modern care that compares with the best in the world, whilst the public sector services vary drastically according to urban and generally peripheral or rural settings, in terms of quality offered to the general population. This quality varies from good to very mediocre, but generally cannot meet the demands of quality, due to scarce budgets, untrained staff, a shortage of skilled health professionals, a lack of work ethics and very poor accountability compromised by unproductivity and other debilitating factors, such as corruption and poor health infrastructure." If the NHI is implemented in South Africa any time so, it will most certainly destroy the private health sector because people using this sector will also have to contribute to the NHI. In reality they would be paying twice for healthcare.

Post 1994, the democratic government led by the majority party in parliament, the African National Congress had no alternative but to restructure the inherited apartheid health sector, in wanting to make the services more accessible to all and decentralized the public health structures to districts across the nine provinces, yet maintaining control in respect of policy making and budgetary requirements, at the central level within a unitary state. Primary Health became free with emphasis on pregnant women and children less than six years of age. The rest of the population, desirous of using the healthcare facilities and its services are required to pay on a means test determined by government. Generally the tariffs for the services are a fraction of private healthcare charges. The District Health System(DHS) was now charged with the responsibility to deliver healthcare along the Primary Healthcare Model (PHC). Naturally, due to the mammoth inequalities that were inherited from the legacy of apartheid healthcare, in respect to private versus public provisioning of health, the government had to intervene decisively and this prompted necessary regulatory frameworks, in an attempt to rectify imbalances with the primary aim to better distribute resources and provide accessible primary healthcare to the majority poor population that straddles the length and breadth of South Africa. Thus the desire to implement the NHI as a policy to healthcare is a move in the right direction, for purposes of affording universal health coverage to all irrespective of race. There is no argument with regards this noble initiative but, the timing, costs, the plan and the effects upon private healthcare users, the state of the public healthcare services, it hospitals and clinics which are in disarray must first be looked at very seriously by government before any implementation takes place.

Doubts over South Africa's Costly Primary Healthcare

The Business Day (2008 and the South African Health Review, 2008) in terms of Primary Healthcare in South Africa states as follows and their appraisal no doubt is pertinent today even after eight years of their initial reports that were tabled to the government of South Africa. In spite of their recommendations and reasoned nuance in terms of Primary Health Care, not much has improved in this regard. The Reports state as follows:

After nearly twenty years of democracy, post 1994 and the comprehensive introduction of primary healthcare as a policy imperative by the national government and, its incorporation into district healthcare programmes across the provinces, it appears that very serious doubts have now (in December, 2008) been expressed about a very costly PHC programme and with very little effect upon the health of its recipients. This will most certainly have very serious health implications and ramifications for South Africa and its health system but, moreover upon the poor as recipients of PHC. The South African Health Review (Chapter 1 on financing) for primary healthcare published by the non – profit Health Systems Trust (2008) and also reported in the Business Day (2008:1, December 24) reports that "government spending on primary healthcare has risen almost eight times faster than the increase in patient visits to clinics over the last three years, raising the question as to whether South Africa is getting value for money. Public sector spending on PHC has grown 8.6 percent a year (in real terms) over the past three years from R8.89 billion in 2004 – 2005 to R13.8 billion in

2007 – 2008. Yet according to the report, the number of patient visits to PHC facilities rose only 1.3 percent a year, from 103 million to 104 million. More information is required to determine thoroughly whether South Africa isreceiving, better quality of care for the increased expenditure. The review reports that many of South Africa's health indicators, such as maternal mortality and tuberculosis care rates, compared unfavourably to peer countries, for example South Africa is only one of twelve countries in the world where child mortality is getting worse, due largely to the lack of effective HIV / AIDS prevention programmes." Earlier in the year 2008 the Lancet Medical Journal showed that "South Africa was almost certainly going to fail to meet the United Nations Millennium Development Goals of reducing child and maternal deaths by two – thirds and three quarters respectively between 1990 and 2015., as the child mortality rate had increased from 60 to 69 deaths per 1000 live births between 1990 and 2006, while maternal death rates had remained unchanged." South Africa had miserably failed to meet the Millennium Development Goals which speaks to the lack lustier healthcare performance over time.

The Health Review and the Business Day (2008) went on to state that "Just over a fifth of the government's total health spending (excluding HIV /AIDS) was earmarked for PHC and is set to rise from R15 billion in the current fiscal year (22 percent of the total R87.7 billion set aside for public health) to R19.2 billion in 2010 – 2011 (22 percent of the total public health budget of R97.3 billion). The funding allocation signals the government's commitment to the principles of PHC. The question arises, is this enough? The report suggests that, public sector spending on PHC, which was R337 per head in 2007 – 2008, should increase to R400 – R444 per head per year for a patient visit range between 3 and 3.5 a year. The Treasury's current budget allocation does not see funding increase to this level until 2010 – 2011, when it is projected to be R395 per head. The analysis also suggests that more than half of all district health authorities are underfunded. This is a very serious problem, in respect to the promotion of PHC as a driving force of the healthcare system and the implementation of the NHI of South Africa." Commitment by the government is plausible but it does not appear that this commitment translates into action in terms of the deficiencies in funding and above all to accountability, productivity and service delivery of the PHC programme which must for all intents and purposes be the backbone to the proposed NHI implementation plan.

South Africa's National Health Insurance Scheme (NHI)

The proposed National Health Insurance scheme of South Africa is an important and controversial issue that permeates the healthcare environment of the country currently. In short it is government's intention and emerging policy to provide healthcare for all South Africans on the basis that many citizens do not have access to proper healthcare, particularly the historically marginalized and disadvantaged populations. This is coupled with the reality that the majority of South Africans have difficulty monetarily to access private healthcare through medical aid schemes, because of the exorbitant costs. The National Health Insurance (2011) outlines the scheme (NHI) and (SHI) as follows in terms of the salient issues:

- "Social Health Insurance (SHI): Refers to compulsory contributions normally provided through a system of payroll contributions into a health fund while NHI refers to combined tax revenue and SHI funds to create a larger pool of revenue for universal coverage.
- Both are based on the principle of revenue collection, pooling of resources and purchasing of services.
- This normally focuses on coverage for the formally employed, and sometimes their dependents as well.
- One of the key elements of SHI and NHI is cross – subsidization of lower income earners by the wealthy (rich subsidize the poor).
- It is easy to deduct tax from payrolls, therefore financing via this mechanism is reliable and sustainable."

Dr Joe Kutzin of the World Health Organization (2007) states that "in the European Region, fragmentation of health services poses a serious risk towards attaining universal coverage." In other words the South African healthcare system is fragmented and therefore poor people have access to a health programme in the United States for example which is geared towards low – income families, but the pitfall is that poor people are often subjected to "second class" healthcare because doctors complained that they were losing money from paying patients. The South African Health Minister has said that **"**NHI would work in the country only if the quality of public healthcare was improved dramatically and, if the cost of private healthcare was addressed, and that the present access to healthcare was made difficult because of fragmentation" (2015). This is testimony of the reality that the South African public healthcare system is in chaos and has to be improved. On the other hand the Minister of Health also indicates that there will be interference with the private healthcare services and lays the blame on fragmentation rather than dealing with quality and productivity of the public healthcare system.

Post - apartheid in 1994 South Africa woke up with two healthcare systems not based on one's skin colour, but based on the depth of one's pocket and whether one had a medical aid. There has to be the establishment of a pricing

commission to tackle uncontrolled commercialism and the exorbitant cost of private healthcare. This poses a threat to the successful implementation of NHI. Currently commercialism in South Africa's health sector is uncontrolled. This is due to the poor public health sector that allows no confidence even by ordinary citizens to the mediocre public healthcare system. The NHI has to be enhanced in terms of service delivery before the government can consider its much needed implementation.

ISSUES AS THEY RELATE TO THE IMPLEMENTATION OF THE NHI FOR SOUTH AFRICA

Funding Proposals of NHI Keenly Watched

Tamar Khan (2015: 1) states that "The long – awaited white paper on National Health Insurance (NHI), which paves the way for sweeping reforms to the health system, will soon be released by government. Given the current fiscal constraints and a South African economy which is in tatters, there will be more than keen interest in the proposed financing mechanisms. The private healthcare industry will also be closely watching what the government has to say about its future role. The White Paper is the next step in policy development after the release in August 2011 of the green paper on NHI, which proposed implementing it over the following 14 years. It promised a health system that was free at the point of use, but did not spell out the services patients could expect or how it would be funded. At the time its costs were projected to rise from R125 billion in 2012 to R214 billion in 2020 and R255 billion in 2025." The costs are exorbitant and when implemented could be substantially higher and perhaps unaffordable. The Health Minister is expected to brief the South African Medical Association, South Africa's biggest doctor organization, on the government's plans. In August of 2015 the Minister told parliament that "NHI envisaged purchasing services from both public and private sector providers" (Parliamentary Briefing, 2015). A month later according to Tamar Khan (2015:1) the Minister told the Hospital Association of South Africa's annual conference that the white paper included measures to regulate where doctors work, using a certificate of need to place them where the state deemed they were required." On the othe4r hand in February 2012 (SA Treasury briefing said that "Its initial modelling showed a rise in taxes, most likely a payroll tax, would be needed to fund NHI. Other options included higher value – added tax or a surcharge on income tax. The Treasury also indicated at the time that user fee might be applied for some health services, to prevent overuse." It can thus be observed that the government is sending out conflicting messages and if value – added tax and a surcharge on income tax would be needed to fund the NHI, it will be a non – starter because the majority of the population are poor and moreover there is a very small tax base of some 5 million people who are already over taxed. The government is being disingenuous because it has not worked out the sums for funding and has not truly modeled the costs and funding modalities for the implementation of the NHI.

NHI Squeeze Coming

The middle class will have to pay more tax and will not be able to use medical aid schemes to fund most private healthcare procedures, if the minister of health and the government gets its way by pushing through the implementation of the NHI. The imminent release of the NHI policy which was promised for the last three years was finally released by the Health Minister on Friday the 11th of December, 2015 in haste and, as a camouflage of the Machiavellian debacle created by the President of South Africa Jacob Zuma "in firing a competent Minister of Finance, which saw the South African economy tumble into shambles amidst the possibilities of a further downgrade of the economy by rating agencies to a possible 'junk status economy, as the country lost more than R194 billion in a matter of four hours" (Karodia, 2015). It is against this background that the South African government had to showcase the NHI in order to diffuse the situation to show South Africans that they had their interests at heart. It was a mere public relations exercise to mask the realities of the South African economy. The ruling ANC government attempted to hoodwink the South African population by showcasing the NHI as a major social intervention, looking after the interests of the people. The White paper states that the fund would pay the state and private sectors for services but it is not clear who would be allowed to use private hospitals and who would use state hospitals. Katherine Child (2015:1) points out that "Medical aids will be allowed to provide complimentary cover for services not covered by NHI and the role of medical schemes; once the NHI is implemented within the health system must change in terms of the conditions set out by the White Paper." Brian Ruff (In Child, 2015:1) indicates that "the NHI White Paper proposes the end of private comprehensive medical aid cover."

'The NHI Will NotSurvive Legal Test'

The government document (2015) "predicts that that there will be fewer medical aid schemes than the current 83. According to the document government medical aid schemes such as the Municipal Workers scheme and the Government Employees' Medical Scheme (GEMS), will reallocate the monthly premiums they take from workers into the NHI fund. This could mean that the middle class will be forced to use state facilities and services. According to the document (2015) "when the NHI is fully operational the tax credits that medical aid users earn each month will be revoked and redirected to the NHI fund. It calls for a complete 'reform' of the health system in both the way services are provided and how doctors and hospitals are paid. It states that health must not be treated as a'commodity' but as a 'social good.' It slams the fact according to Child (2015: 1 – 2) that" the 16 percent of the population using private healthcare spends the same amount each year as the government spends on 84 percent of the population dependent on state healthcare." No one argues about this fact but it must be acknowledged by government that it cannot provide the same quality of healthcare as the private providers given the disarray of the public healthcare services and the inefficiencies within the system together with poor infrastructure and even poorer medical equipment and shortages of essential medicines, the long queues and the poor work ethic within the public health sector. On the other hand and by the same token, it negates the fundamental tenets of democracy for people to exercise their own choices in choosing the type of medical care that they want to purchase andstymies the basic tenet of democracy in South Africa enshrined in the Constitution and the Bill of Rights. It also negates free market capitalism which the economy engages in and an economic model that it has chosen post 1994.

It states that doctors are over – represented in the private sector. This is true but the government salaries are inadequate and the rural infrastructure does not cater for trained medical professionals with poor medical facilities. A purposeful reading of the government's NHI policy paper is absurd, superficial and irrational. In reality no aspect will survive a legal challenge. These legal challenges discusses the NHI in terms of what the White Paper does not discuss and is taken from the South African media in terms of the legal aspects and is summarized from the work of Neil Kirby in the Legal Times of the newspaper The Times dated Friday, January 22(2016: 2) and is as follows:

"The NHI as "a substantial policy shift will necessitate a massive reorganization of the current healthcare system, both public and private, and also derives its mandate from the National Development Plan (NDP) of the country."A number of details are omitted and therefore, it is appropriate to deal with certain of the primary issues not dealt with in the White Paper about a possible NHI in South Africa. These omitted issues will dent the implementation of the South African NHI plan and therefore will not stand up to the legal challenge. These legal challenges are discussed hereunder as follows and emphasis is added by the authors:

1. "**Constitutionality** – The concept of the NHI which is premised on universal healthcare coverage, means that every South African will be required to join the NHI, whether they wish it or not. In addition, with what appears to be a reduced role for private healthcare funding, as stated in the White Paper, there may not be a choice but to join the NHI. Such a mandate may not pass constitutional muster insofar as the Bill of Rights is concerned. Section 18 guarantees every person the "right to freedom of association." Therefore, forcing one to belong fundamentally to a national healthcare club may unfairly and unduly limit one's right to decide with whom to associate being the NHI or a medical scheme, for purposes of securing healthcare funding and assistance.
2. **Quality of Service** – 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 National Health Act 61 of 2003. 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 following statement is made: "Quality 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 utilization due to the high burden of disease and increased patient loads have further compromised the quality of care" (Neil Kirby, 2016:2). Quality remains a concern and arguably a central reason for distrust in the South African public in respect of receiving healthcare from a public institution. Without significant improvements in the quality of healthcare services at public facilities, there will be resistance to the implementation of an NHI, irrespective of the constitutional or otherwise legal basis, if any, for such a system.
3. **Services** – 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. However, the White Paper lacks the requisite detail in respect of the scope and ambit of the services to be provided vis – a – vis the services currently purchased by users in the private sector, for example. Therefore, at paragraph 131 of the White Paper, certain services are described as being the services to be

4. provided by the NHI, albeit that a qualification is included in paragraph 131 that these are services to be included in an NHI. These services are described as follows:

i) Preventive, community outreach and promotion services; ii). Reproductive health services; iii). Maternal health services; iv). Pediatric and child health services, v). HIV and AIDS and tuberculosis services; vi). Health counseling 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."

It is unknown what services are embraced with references to prescription medicines" or palliative services." However, the White Paper does 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 hospital – centric without fully addressing the burden of disease." The emphasis of the NHI is on preventive services and not curative services, which arguably means that the NHI, as proposed, may miss the point in the context of healthcare in South Africa insofar as the existing burden of disease is concerned.

5. **Traditional Healers and Complimentary Medicines and Related Disciplines:** No mention is made in the White Paper about any involvement of or contribution by either African traditional healers or the allied health professions and complimentary medicines, all of which are now subject to formal recognition and regulation.

6. **Payment:** Chapter 7 of the NHI deals with the "financing of the 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. Once again, being forced to join a national healthcare club, which is commented on above in terms of section 18 of the Bill of Rights, is problematic, but is further compounded by the imposition of a requirement to make payment for the privilege of joining the club. The imposition of a requirement to pay to join the NHI seems to contradict one of the objectives of the NHI, which is described in paragraph 107 as "promoting equity and social solidarity through the pooling of risks and funds," read together with the statement in the introduction 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 the Republic at large in the current and medium term economic circumstances in which it finds itself.

7. **Property:** At paragraph 401 of the NHI, the statement is made 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 NHIservice benefits. Part of this work will require a complete overhaul of 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 healthcare services by everyone within available resources." The White Paper also states the number of medical schemes in the country will reduce to "a much smaller number" (at paragraph 402). The effective removal of the ability of a medical scheme to provide benefits and charge for such benefits accordingly may constitute an unlawful infringement of a medical scheme's right to property.

Therefore, the structuring of the NHI so as to deprive medical schemes of the ability to provide services and to structure their affairs accordingly, as is currently the regime under the Medical Schemes Act 131 of 1998, as amended (The MSA), may constitute a taking of property that is prohibited by section 25 of the Bill of Rights. In terms of the MSA, medical schemes constitute juristic entities, and are required to run their affairs accordingly and to be held accountable in terms of the MSA. The NHI does not explain why the role of medical schemes must change under the NHI as proposed, or even what is achieved through such a change other than the removal of the desire by consumers to purchase private medical scheme cover as opposed to belonging to an NHI.

The NHI is to be implemented in phases in accordance with the provisions of Chapter 9 of the White Paper. The first phase, which extends from 2012 to 2017, deals with so – called "health system strengthening initiatives," the establishment of an NHI Fund, the movement of central hospitals to the national sphere" and establishing the Office of Health Standards Compliance, District Health Management Offices and the National Health Commission. Steps will have to be taken very carefully, as the NHI brings with it controversies relating to both the scope and ambit of the services to be provided and the costs of providing those services, the imposition of taxes and levies, and the constitutionality of forcing people to belong to a system and then nevertheless requiring them to pay for that privilege. Presumably, based on the time periods applicable to the implementation of the NHI, time will tell. Certainly there will be a legal challenge to its implementation in its current form" (Neil Kirby, 2016: 2).

Anuschka Coovadia (2016:22) states that the NHI is a healthy dose to cure South Africa's sickly healthcare system and therefore curing the ailing healthcare system would be directly linked to enhancing our pool of human capital,

improving labour productivity, pursuing stronger economic growth and embedding greater social stability and cohesion into our societies. Resources are scarce, so the existing wastage and leakages in the system could indisputably be put to better use." She further points out that "South Africa has a meager 0.776 medical doctors per 1000 population compared with Brazil's 1, 891, China's 1, 491 and the United Kingdom's22, 809. That only 3 percent of newly qualified doctors will end up working in rural areas. Considering that about 38 percent of the South African population lives in the rural areas, the shortage of doctors there is critical." It is most clear that the implementing of the NHI will require a major scaling up in public funding for healthcare, which the country can ill afford currently because of the poor economic climate. In reality "healthcare systems are ultimately a reflection of the societies in which they develop, the fundamental changes in South Africa's health system mirror the desire for change in the country" according to Anuschka Coovadia (2016:22). Equity, inclusivity and patient centricity must demonstrate our core values as a nation and the hope that, one day, every South African will get the care they so desperately need and deserve. In this regard the government has a long march to undertake and much work still needs to be done by the Health Ministry in implementing the South African NHI programme.

Katherine Child (2015: 2) states that "Instead of trying to improve health services in the state sector, it is attempting to change how health services are provided to people with medical aid. It is focusing on 9 million people who already have good healthcare. In this regard the White Paper (2015) states that:

- "Private healthcare costs must come down;
- Private ambulances will be forced to help all patients, not just those who can afford private care;
- Hospitals must have functional laundry and security services;
- Management and quality of state hospitals must improve; and
- The middle class will not be able to go to specialists direct but will have to use a general practitioner first, who will refer them to a specialist if needed.
- It is not clear as to how the NHI will be funded."

The policy document predicts that, if the economy grows by 3.5 percent a year, the government will be short of R71 billion in 2016 when the NHI is scheduled to be fully funded. If it reaches only 2 percent a year, the fund will be short of R108 billion from 2016. The document suggests various remedies, such as hiking Value Added Tax (VAT) by 2 percent, deducting NHI contributions from salaries and increasing personal income tax. It envisions moving spending on private healthcare into the public sphere. The issue is can the government sell these proposals to the middle class and if it is at all economically viable. Government proposals as they stand are 'pie in the sky' because there are only about 5 million taxpayers in South Africa and therefore taxing them further will be a non - starter. Increasing VAT is not an option because it will affect the predominantly poor population. On the other hand the government itself has downgraded its growth forecast to 1 percent from a possible 1.6 percent over several years to come. Rating agencies and other world financial organizations has lowered South African growth over the next few years to 0.7 percent this year to a maximum of 1.5 percent up to the end of 2019 /2020. This is the reality that the South African government and its Ministry of Health have not factored into the NHI funding equation. As things stand, the NHI is currently a non – starter and cannot be implemented in the short term. It is a recipe for disaster. In other words"the NHI is still looking for finance. It is unpredictable. It has great implications for the South African economy" (Mia Malan, 2015: 6). "Good infrastructure is cardinal and crucial for the effective provisioning of health services in South Africa and more especially for the implementation of the NHI". It is no secret that the South African health sectors infrastructure is in tatters. In reality from the provision of medical personnel, laboratories, poor hospital and clinic infrastructure and all round provision of services including medical equipment is in short supply and that the infrastructure cannot meet the demands of the population. This reality throughout all the nine provinces of South Africa has not dawned on the government and as such, before drastic improvement of the public healthcare sector the NHI as it stands is doomed for failure.

A SKETCHY GRAND PUBLIC HEALTH VISION

Eight years and two policy papers following a resolution by the African National Congress (ANC) to implement the NHI, there are still yawning gaps in the government's plans to provide universal health coverage for all South Africans. The scheme has long been on the governments agenda, but came to the political fore only after the ANC's 2007 elective conference held at the city of Polokwane in the Limpopo Province. The Health Minister who assumed office in 2009 has been under tremendous political pressureto deliver on his promise because in 2011 he published a broad outline of the government's plans in a green paper on the NHI. However, the White Paper released by him around the 8th of December, 2015 for public comment continues in the same vein as the green paper. It sketches a grand vision of a public health system that within 14 years will provide free services at the point of delivery, but it fails to nail down the specifics of benefits, the mechanisms the state will use to purchase healthcare services from providers, what it will cost,

and how it will be paid for. The government is proposing a sharp curtailment of medical scheme benefits, limiting them to 'top up' to the benefits provided by NHI. This is sure to alarm consumers and the industry, and is almost certain to face a legal challenge. Although the National Minister of Health "lamented the high cost of services of private medical aid schemes, he ignored the elephant in the room, a more effective way to protect consumers would be to amend the Medical Schemes Act to tighten oversight and improve governance of medical schemes ripe for plunder" (Business Day, 2015:3). There is no doubt that the Minister of Health is out of depth in his analysis of the implementation of the NHI and this is seen by his hostility to the private healthcare sector. Both the Green and White Papers on the NHI, fail to take into account South Africa's current fiscal and economic crisis. Both papers assume that the South African economy will grow at 3.5 percent per annum, a rate last attained in 2011. Business Day (2015: 3) states that "The White paper envisages a central National Health Insurance fund that will pay for services delivered at district level, raising a politically sensitive question about the future role of the already dysfunctional provincial health departments, which receive the lion's share of the health budget because they deliver most public health services." It appears the provinces have yet to be consulted, since rather than spelling out how the inters – governmental funding arrangements will be modified, the White Paper says that major changes are likely. Establishing the fund will be relatively simple, but shifting responsibilities and funds from provinces will be anything but easy. There is no doubt that much more work needs to be done and undertaken before enabling legislation can be drafted. It is a marathon and indeed not a sprint.

The health scheme is scheduled to be functioning by 2025 but the precise costs are still not known. In just 10 years from now, South Africans could be paying significantly less for private health services; spending an entire day at a public clinic waiting to see a doctor, if at all, wi9ll be a thing of the past and there will be no more out – of – pocket payments for medication or treatment. This is the healthcare system envisioned by the governments proposed NHI. The idea is a blueprint detailed plan of reforms in both the public and private sectors to make affordable, good – quality healthcare accessible to all South Africans. The implementation of the NHI is most likely to be politically controversial, as have similar far – reaching overhauls of health systems in other countries. But South Africa is following a well – blazed path, and one with much multilateral backing, such as:

- " A 2005 World Health Organization member states, including South Africa's commitment to ensuring that all people have access to health services they need without risk of financial ruin or impoverishment;
- A 2012 United Nations resolution urging governments around the world to move towards universal health coverage; and
- The inclusion of universal health coverage in the sustainable development goals" (Mail and Guardian, 2015: 12).

According to the Mail and Guardian (2015) "Countries such as Brazil, Norway and Mexico have similar systems in place. The results have been largely positive. Research indicates that middle income countries, such as South Africa, that are implementing NHI type systems have benefited from a healthcare population. The White Paper estimates that a one year increase in a nation's average life expectancy can increase GDP (Gross Domestic Product) per capita by 4 percent in the long run." In South Africa, only 16 percent of population belong to medical aid schemes and have access to private medical treatment. The remainder of the population depends on the public health sector for health services, which are often of a much poorer quality. This is a very serious issue and problem, which has to be addressed immediately by government and before any implementation of the NHI is considered. Speaking at the release of the white paper on the 11 of December, 2015 the Health Minister said "The existence of medical schemes in South Africa is a punishment for poor people" (Mail and Guardian, 2015), because 80 percent of the specialists in South Africa work in the private sector where they treat only 16 percent of the population, about 8 million people, considering that South Africa has a population of more than 54 million people. It has been repeatedly pointed out by the Minister that health service prices in South Africa are very close to those of the United States, which has the most expensive healthcare system in the world.

Although it has taken four years since the publication of the green paper for the NHI white paper to be released, there is still no indication by government as to how it will be financed, but the health department is determined to introduce the scheme. The Mail and Guardian (2015) points out that "The NHI will be implemented over a 14 year period, which will be divided into three phases. The first, which started in 2012 and is due to run until 2017, will see the NHI "tested" in 11 health districts. The main focus of the pilot scheme is to fix the system and lay the foundation for the NHI." Nothing tangible has thus fat been achieved in this direction. Since 2012, several reforms have taken place, such as the introduction of the integrated school health programme (very slow progress, if any at all has been thus far achieved), district clinical specialist teams (there is a drastic shortage of specialists and no real progress has been registered in this regard), and the establishment in 2013 of the Office of Health Standards compliance (not much has been achieved in this regard considering the very poor health services in the public sector generally). There are tremendous systemic failures within the public health services that require rectification on the part of government. The second phase, which is due to take place over five years, between the 2017 /2018 and 2019 / 2021 financial years, will see funds from the Compensation Fund and Road Accident Fund being redirected to the NHI Fund. Subsidies paid to medical schemes by government departments will also be allocated to the fund, which is due to be fully functional by end of the phase. The

registration process for people who will be covered by the NHI will start in this phase, with vulnerable groups given priority. The third and final phase will take place over four years, between the 2021 /2022 and 2024 /2025 financial years, when a mandatory contribution in the form of taxes will be enforced.
According to the Mail and Guardian (2015) "The NHI Fund will contract private hospitals and specialists to provide services where the government is unable to. By 2015, medical aids will only provide top – up cover to pay for services such as elective cosmetic surgery that will not be paid for by the NHI. When the scheme is in full swing there will only be one health system. By using their NHI card, South Africans will be able to access health services from any doctor or clinic, public or private that is certified and accredited by the NHI." In other words the scheme will provide a comprehensive package of health services, but it will not cover everything for everyone. All healthcare will be provided at the primary healthcare level, and hospital and specialists will only be for referral. In this regard the White Paper (2015) states that "Though it is not as yet finalized, the basic NHI package will cover the following services: HIV and tuberculosis, reproductive healthcare, optometry and mental health." Implementing such reform which is necessary given the history of apartheid healthcare which excluded the majority poor population is a mammoth task that the government wants to undertake. This will require a new vision, government commitment, the political will, skills, resources and leadership. This also requires a buy in from the private health sector and the guarantees of the huge additional funding required. In policy terms, 2025 is not all that far away but, given the current economic and fiscal crisis confronting South Africa but, it may be a dream that will have to be deferred.

Nhi Could Make The South African Economy Sick And Cripple Taxpayers Already Buckling Under The Load

There is no doubt that the cost of the proposed national health insurance scheme has been vastly underestimated by government and its economists and technocrats. The NHI could thus cripple the South African economy and no doubt if implemented would most certainly be an added burden on the taxpayer." This is according to Jason Urbach, an economist and a director of the Free Market Foundation (In the Times, 2015: 6). It could lead to the demise of most medical aid schemes. The times (2015: 6) indicates that "R108 billion a year, on top of the existing health budget of about R146 billion, would be needed from 2026. This is based on a projected 2 percent growth of the economy." But Urbach's calculation (2015: 6, in the Times) "suggests that NHI would cost at least R367.4 billion a year. This estimate is based on medical aids spending a minimum of R567 per member per month on the healthcare services they are legally required to provide, covering about 300 medical conditions. That is more than the income tax paid by 6 million people last year." Considering these figures one starts to understand the futility of the proposal. It is therefore obvious that the already heavily taxed South African citizen would be taxed even further in very serious depressed economic times, because taxes will have to be hiked, including higher VAT or an employee tax that have been suggested. A VAT increase creates inequality whilst an employee tax would be a disincentive to job creation. It would drive out health workers from the country and thus create a huge and expensive new government bureaucracy. Urbach (2015: 6, In The Times) "Citing the British National Health Service, which is in the red by about R184 billion and that, even developed countries were struggling to fund free healthcare." As things stand currently, it will be wiser for the South African government to purchase health services for the poor from the private sector. In other words the government could act as a financer and let people decide for themselves where to spend their money – the public or private sector. There is no doubt that competition will improve services. It must dawn on the government of South Africa that given the very poor state of the economy a country that has drastically mismanaged its economy and is broaching a recessionary climate and the possibility of a ratings downgrade toa 'junk' status, the government must avoid inflicting further pain on South Africans by increasing taxes to fund the NHI.
On the other hand the NHI "could help meet shortfalls.' Kamcilla Pillay (2016:6) states that "South Africa's plan to implement NHI without falling into the trap of over – promising and under - delivering- could help deal with its healthcare shortfall." In his book titled In Search of the Perfect Health System, the chairman of the global health practice at KPMG International, Dr Mark Britnell, examines healthcare systems in 25 different countries, each with its individual strengths and weaknesses, each struggling to provide effective, affordable care to meet growing demand. A synopsis of the key arguments in the book is put forward by Kamcilla Pillay (2016: 3) and this is captured below as follows:

- "The government , according to recent reports, has established pilot districts for the proposed national health insurance in all nine provinces, and the Treasury set aside R81.1 billion over three years in the 2014 budget review to revamp and build hospitals and clinics and other infrastructure for the programme.
- Spending on health will grow at 8.3 percent a year over the next three years.
- It's right that South Africa should proceed with NHI. There have been many broken promises in the past and this has led to cynicism and mistrust, between the people and government and the public and private sectors.

South Africa already spent 8.9 percent of its GDP on health, but life expectancy was still less than 60 years.

- More than 84 percent of the population relied on the public health system.
- The quality of health workers was also a concern with the private sector attracting 70 percent of newly qualified doctors through better pay and conditions.
- South Africa also shouldered a major AIDS burden and an increase in lifestyle diseases in the country.
- South Africa spends more on health than any other Brics (Brazil, Russia, China, India and South Africa) nation, but yet the returns are very poor.
- With the exception of Russia, all other Brics nations are moving ahead with universal health care.
- Brazil has done wonders with limited finance and medical staff because it concentrated on building community services. China has covered an extra 500 million people since 2009 and now, universal healthcare for 98 percent of the population.
- India had aimed for universal care by 2019.
- South Africa has been talking about it at least since the Freedom Charter of 1955.
- Most countries take at least 15 years to develop universal healthcare.
- A healthier population is a more productive population which generates more economic health and wealth.
- Health is a value, not just a cost."

The research of Mark Britnell (In Kamcilla Pillay, 2016: 6) revealedthat "There was no one perfect system, but a system could be formed by drawing on high performing national plans.

South African Minister's Prescription for Health as Concens the NHI is Incoherent

The foregoing analysis captures the issues raised in this paper and draws on the opinion piece written in the Business Day Editorial (2016: 11), which states that "the Health Minister of South Africa has placed on the table and, for the nation an NHI plan that is totally an incoherent prescription for health. The opinion as an editorial is written by Leon Louw a respected political analyst (2016: 11) goes on and enunciates as follows:

"If you think that healthcare is expensive, wait until you see how much it costs when it is 'free.' If you lament the deplorable state of public healthcare, wait until you see how bad it is after they 'improve' it. Healthy people who felt ill after reading the White Paper on NHI should call their doctor _ _ _before they lose their right to choose. Informed people know that 'NHI' and the penumbra of policies surrounding it entail the opposite of insurance. The White Paper proposes socialization at the expense of insurance. There will be "insurance" if the government turns its 4200 healthcare facilities into transformation and empowerment opportunities, with it being the private care insurer of last resort. Instead of unhealthy facilities, it could liberate thousands of opportunities for the provision of quality care at no extra cost. During the White Paper debate, Health Minister Aaron Motsoaledi said he wanted "universal healthcare" without seeming to appreciate that there are better ways of achieving it. He offered no reason for believing this would require the destruction of consumer autonomy in a capitalist and free market economy that South Africa is post democracy in 1994. The Constitutional right to healthcare, he said, implied the suppression of private care. That is as irrational as saying the corresponding right to housing, education and other "second generation" rights requires the suppression of private provision. The healthier approach of other ministers is to welcome private alternatives to the overstretched public sector

The NHI fantasies clash with prohibitive costs. Motsoaledi seems to imagine substantial tax increases to be a feasible source of limitless revenue. In a moment of realism, the White Paper concedes "payroll taxes" might increase unemployment. Higher personal income taxes affect "disposable income" (and) economic activity and have a "negative impact on savings." NHI financing requirements are "uncertain." At current rates, the cost of 'minimum benefits" would be R374.2 billion, whereas personal income tax yields only R251.9 billion. Minister Motsoaledi repeated his "exorbitant" cost of private care mantra without appreciating the illusion that healthcare costs outstrip inflation. Spectacular improvements in healthtechnology cause costs to rise initially, and then fall. Medical advances entail added costs. Anesthetics add anesthetists; brain surgery adds brain surgeons, robotic surgery adds robots, and Viagra adds virility at a previously nonexistent cost. Life expectancy, thanks to better care, adds costs that rise exponentially with age. Comparing like with like reveals falling costs. When patents expire, cheap generics flood the market. Prices fall when initially costly equipment is mass produced.

Health Minister Motsoaledi's falling popularity matches falling prices he thinks are rising. The Democratic Alliance (DA) the largest opposition party in South Africa adores him so much that he topped its Cabinet "scorecard" with straight A's until last year, when it downgraded him to C due to "non - submission" of annual reports _ _ _failure to meet _ _ _targets_ _ _ bills and regulations stuck in the ministry and _ _ _unacceptably low _ _ _bureaucracy." The Mail and Guardian found the Health Professions Council of South Africa "in a state _ _ _ dysfunction." In Business Day, Michael Settas enjoined him to "focus on internal efficiency rather than the NHI." Neil Kirby of Werksmans Attorneys thinks "many areas" of the proposals may be unconstitutional. The obvious way to cut costs is to allow competition, to which end he should scrap the apartheid – era "certificate of need" requirement, according to which little grey bureaucrats

throttle supply and inflate healthcare prices. As Thomas Sowell observed" "It is amazing that people who think we cannot afford doctors, hospitals and medication somehow think that we can afford doctors, hospitals, medication and a government bureaucracy." As things stand and as controversy rages in the country the implementation of the South African NHI must be put on hold because its prescription for healthcare is incoherent. It has to be reevaluated there can be no argument about this but at the same time universal healthcare for all is an absolute necessity given the legacy of apartheid healthcare. In setting out a framework in which health law and policy must be further developed and implemented and the fact that, healthcare is a basic human right. The Health Minister of South Africa seems to be undeterred. The NHI, as laid out in the White Paper, is inevitable but the Minister has to tread cautiously or it will blow – up in his face and could lead to further deterioration and total destruction of the healthcare system in South Africa.

The South African Health Minister Does A U – Turn On Proposal To Slash Medical Scheme Benefits

As usual the emotional responses to the implementation of the NHI by the South African Minister of Health has come to naught for the time being and Tamar Khan (2016: 1) reports that "In a surprise move the Health Minister has distanced himself from a controversial proposal in the White Paper on NHI to slash benefits offered by medical schemes, saying the state should not limit patient choices." This is the state of affairs in South Africa on almost all public issues including healthcare were emotion and rhetoric is the order of the day rather than engaging in sustained and rational debate and, allowing the misguided notions of politics that encompass policy making to the peril of the nation causing policy errors that hurt the country. It appears that South Africa after 21 years of democracy is living in the past of its revolutionary credentials**.** The time has come that the ruling ANC dispenses with these misguided political notions and converts itself to a genuine political party, in order to avoid chaos.

The White Paper, sponsored by the Minister's Department, was approved by the Cabinet and released for public comment on December 11 of 2015. It proposes mandatory membership of NHI, reducing the role of medical schemes to merely providing complementary services. The reasons for the Minister's about – turn remains unclear. According to Tamar Khan (2016: 1) "The Minister also dismissed the paper's cost projections, saying NHI was a long – term project that should be financed programme by programme. He further added (The Minister) that there was a strong future role for private healthcare and a prudent approach to spending on NHI. He also said that we are not envisaging burning medical schemes outright and we want people to make their own choice. We want to make it clear that NHI will be mandatory just like it is in England. No millionaire is not attached to the NHS (National Health Service), but if he says he wants to something privately they will allow it." The continuing responses of the Health Minister makes no sense and it is obvious that theimplementation of the NHI in South Africa is beyond his comprehension and does more harm to citizens and as it stands its costs and services are not fully worked out by an equally inept South African bureaucracy. The Minister in Tamar Khan (2016:1) acknowledged that the White paper has to be reworked, clarified and sharpened and that, it would not be implemented in one fell swoop and, it was impossible to put a price tag on it because there were too many parameters that could change over time. I want to reassure the nation that you do it in bits and steps. We want to start with Primary Health Care (PHC) and the money budgeted for it about R44 billion is not being used as it should be. Let's start with PHC and with this we can say it is the start of the NHI we are building." All his responses are nothing but cheap rhetoric and have gone on for years without any tangible movement. He does not acknowledge that he is in charge of a dysfunctional public health sector, a completely unproductive health network that for two decades has not served the majority poor population adequately and does the poor a great disservice. The Minister must first fix the dysfunctional public health sector ofSouth Africabefore any implementation of the NHI could be considered. He is playing to the gallery and no one now takes him seriously.

Jonathan Broomberg (2016:2, In Tamar Khan) the CEO of Discovery Health, South Africa's biggest medical scheme said that "We agree with the view that once they have paid the mandatory NHI contribution, members of the public should retain the freedom of choice to purchase private health insurance." This is the practice in virtually every system of NHI across the world. It would also benefit the system as a whole by reducing the NHI's service delivery burden. Tamar Khan (2016:2) reports that there "Remains a pressing need to update, medical scheme legislation, and it is important the NHI policy process does not delay this. Medical schemes are sitting on R10 billion in excess capital and reforms to the solvency regulations for medical schemes would immediately assist with affordability of premiums." Insight Actuaries and Consultants joint CEO Barry Childs (In Tamar Khan, 2016:2) said that "The health system required cohesive reform, including improved regulation of medical schemes, to ensure equitable and quality coverage. These basic tenets have not been understood by the Health Minister and the South African public health sector bureaucracy.

Another Blow to the NHI as Aggrieved Nurses on the March Through Pretoria

According to Prime Time News (ENCA, SABC and ANN7 (February 15, 2016) "A sea of black clad nurses brought Pretoria, the administrative capital of South Africa to a standstill and sang songs about the insensitivity of the

Department of Health and of government in respect to their troubles and laid the fault bear at the feet of the Nursing Council of South Africa." Their anger was also directed to the Department of Health, the biggest employer of nurses in the country. Their demands were about improved working conditions and pay. "We stop work and take to the streets when we want to be heard they chanted but were met with locked gates and a heavy contingent of security personnel" (Makhubu, 2016: 3). The nurses came from across the province of Gauteng, as well as the North West, Mpumalanga and Free State provinces and, were both from the public and private sectors. They were from different political formations and trade unions, united under the mission of demanding economic liberation, professional and academic recognition, improved working conditions and restoration of their image of their profession. According to Makhubu (2016: 3) "They chanted the South African Nursing Council must fall. We are nurses, we heal and do not kill, and we pay the salaries of administrators. They presented a memorandum of demands to the Nursing Council of South Africa and, earlier handed a memorandum of grievances to the Department of Health."
They said that "Government had offered free healthcare, but did nothing to ensure facilities, equipment and drugs were not available. They wanted improved salaries across the different levels of nursing; called for an end to community service for newly qualified nurses; and asked for the right levels and numbers of nurses in health facilities. They also rejected calls for the restoration of the traditional white uniform worn by nurses, and called for practical replacements which were specific, had maximum protection and were durable. They vowed that this was only the beginning and would bring the public health sector to a standstill and would mobilize nationally, in order that nurses get a fair deal from all the authorities"(Makhubu, 2016: 3). This is the state of play in the healthcare services of South Africa and, is a clear indication that the public health sector is in disarray and such a situation is dangerous in respect to the implementation of the NHI. The nurses also said that they are overworked, not remunerated adequately, that the public health services is understaffed, there are small budgets and hospitals are crowded with immigrants and, that, the services are stretched to a point of no return. This exemplifies that all is not well and, that, the government and the Department of Health is alienating the core component of the healthcare services and, this would be a blow to the implementation of the NHI. There are serious systemic and structural problems within the public healthcare system of South Africa. This has to be remedied rapidly, before government can consider any implementation of the NHI.

Recommendations

- It is essential that government consults widely on the implementation of the NHI before any implementation is considered.
- That more research needs to be undertaken by both the private and public health sectors of South Africa in respect of making healthcare more affordable and for the provision of quality healthcare for all.
- The NHI must be viewed as a progressive piece of legislation to redress past imbalances by catering for access to healthcare, but whether it is practicable must be very keenly debated.

- Access to, and quality of, healthcare in South Africa should be improved instead of making it free to everyone.
- Free healthcare must be the ultimate goal but, this can only be done incrementally given the current economic and fiscal crisis that the country is confronted with.
- The government should increase the quality of healthcare in the public sector, pursue increased productivity, slow down inefficiency within the public sector and hold health functionaries accountable for the delivery of healthcare services.
- By the same token government must provide essential medicines and drugs which are in short supply within the public healthcare sector hospitals and clinics.
- In addition it is a government responsibility to see to it that medical staff and doctors are made available throughout the clinics and hospitals particularly in the rural areas.
- It is essential that a thorough evaluation of the Primary Health Care (PHC) programme be undertaken by government because PHC must become the bedrock of the proposed NHI scheme and plan.

ETHICAL CONSIDERATIONS

There are no specific ethical considerations because the issues raised in this paper are already of public knowledge and, that there is an ongoing debate and discussion raging and, taking place in South Africa about the implementation of

the NHI. Therefore, any criticism of government policy in terms of healthcare issues and the NHI is par for the course and is necessary, in order to enhance governance and democratic government in South Africa, which is waning under the current government.

Areas For Further Reserch

- This subject is a volatile issue and therefore, although much research has gone into the NHI implementation plan and its exorbitant costs, it has not been systematically undertaken by government. It is therefore imperative that the plan of implementation be delayed and all modalities of implementation and costs be worked out and thoroughly researched.
- That although universal health coverage must be the aim and goal of the public health system of South Africa, the issues of preventive medicine, primary health care and the reevaluation of the health system must be thoroughly researched and thereafter, there has to be consensus with regards implementation, its duration on the basis of a phased in approach over time.
- By the same token there should be no haste to compromise the private health sector in terms of government wanting to compromise this successful system and, it should therefore not 'cut its nose to spite its face.' The reality is that quality health is provided to a minority using the private healthcare system. The system is working and there should be no interference by government to break a system that is functioning systematically, irrespective of the high costs currently.
- Among the above issues there are a host of other issues that need to be researched by tried and tested researchers to place the implementation issues and costs of the NHI, on the table for government.

CONCLUSION

The South African public health care system is in shambles and is on the verge of collapse, so are many other sectors of public administration. This is due to government ineptitude and the inefficiency of an unaccountable bureaucracy. There is no argument against the implementation of the NHI because pass inequity and imbalances within the health care sector has to be dealt with decisively. However, the government of South Africa should tread cautiously with regards the implementation of the NHI and, it should consult widely and work out precisely the costs of funding the NHI within the ambit of a depressed economic climate and an economy that is only expected to grow at 0.7 percent this year and, in all probability will enter a recessionary cycle. A purposeful reading of the NHI plan indicates that targeting a zero–co–payment scheme is clearly unrealistic. A co–payment system will be more viable. The NHI will most certainly in terms of how it is envisaged by government at the moment will no doubt result in an exponential increase in demand for health care services. The government of South Africa must consult widely and must not tamper unnecessarily with the private health care sector and the medical aid schemes. It must bring these medical aid schemes into line to serve the country in a sustained partnership with government. The NHI must be implemented and there has to be universal health coverage. Its implementation must be delayed until the model is further refined and consensus attained from all stakeholders. The starting point for government must be an over haul in all facets of the public health care sector, including medical personnel, infrastructure and all that contributes to efficiency and sustained quality health care delivery must become the order of the day before any implementation of the NHI will be remotely possible. From the discussion in this narrative, the author therefore makes the following finite conclusions, which are as follows:

- There is no doubt that the NHI must become a salient and important component of the both the private and public health sectors of South Africa and to this end there cannot be any argument.
- That, it would be essential for government to be less emotional and more practical in its approach by not destroying the private health sector dominated by medical aid schemes, which compete and compare, with the best in the world.
- That the White Paper has to be reworked in order to cater for the fears that medical aid schemes have legitimately pronounced upon.
- The costing of the NHI on a programme–by–programme basis would improve predictability and planning.
- Reforms to the solvency requirements of medical aid schemes are urgently needed and must be conducted.
- It is essential and absolutely necessary that government seriously workout the funding models in respect to the implementation of the NHI with immediate effect.
- That government in spite of the White Paper submissions that it will receive via comments from the public and

other health formations consult widely with all stake holders in order to get consensus before any implementation models are considered in auctioning the NHI.

- There is no doubt that given the legacy of apartheid that the democratic government of South Africa has to pursue relentlessly of universal health coverage for the entire population of South Africa, especially the poor and middle–income earners.
- The South African Minister's Plan on the NHI remains controversial and his prescription for health is incoherent.e.

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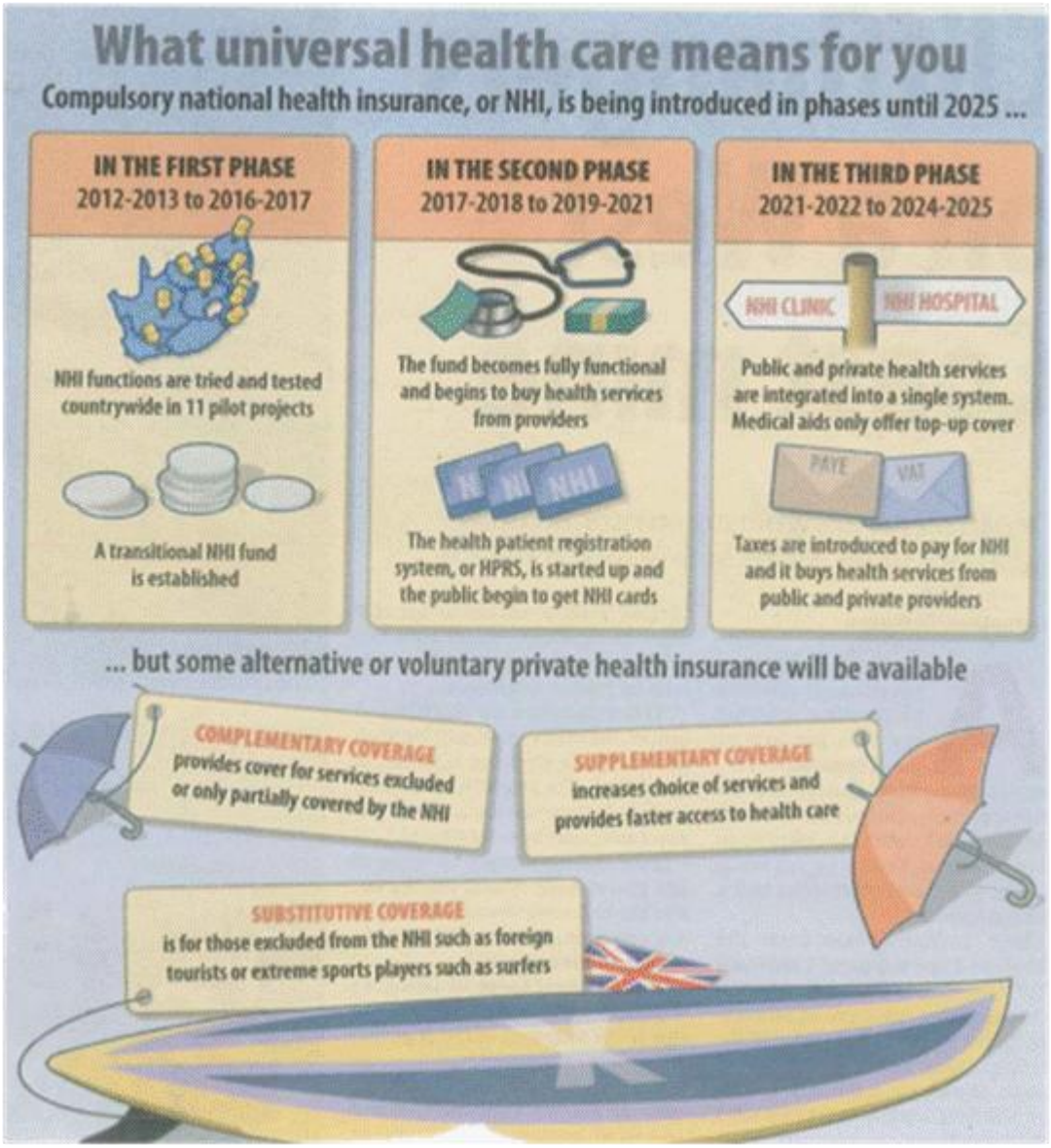
ALL THE NUTS AND BOLTS OF THE NHI

The graphic below shows and depicts the nuts and bolts of the NHI and this is explained in the ensuing narrative:



Source: What Universal Healthcare Means: Source: Mail and Guardian 2016. November 12 to 18. Page 8. Johannesburg. Republic of South Africa