THE ANALYSIS OF PRIVATE AND PUBLIC HEALTHCARE IN SOUTH AFRICA

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TABLE OF CONTENTS

	Page number
Abstract	4-9
Purpose of the study	7
Reflections of the past decade	
According Sanders	8
Figure 1	8
Figure 2	9
Figure 3	10
History of South Africa Pre -1994	11
Right to healthcare	12
Grootboom v State	12
Burden of Care	13-14
Training and recruitment	15
S.A Learning Institutions	15
Medical Universities in S. A	16
Nelson Mandela-Fidel Castro Collaboration	17
Epidemics	17
Mortality Rate	18
Case Laws	19
Analysis of Healthcare	
Current Healthcare	20
Case Laws	20
Public Healthcare	21
Vicarious Liability	22
Case Law	23-24
Compensation System	25
Conclusion	25

Access to health

Case Laws	26
Access to Public Healthcare COIDA	28
COIDA benefits	29
Private Healthcare Facilities	30
Malpractice Insurance	31
Medical Subsidy	32
Medical Aids	32
Case Law	33
Medical Inflation	34
Discovery Health	35
Best Practices	35

Governance

Political Influence	42-43
Figure 4	42
Outcomes	44-45
NHI Fund	46
NHI Model	47
Recommendations	48
Conclusion	48-50
Bibliography	51-52

ABSTRACT

The Bill of Rights[1] enshrines the rights of all people in our country and affirms the democratic values of human dignity, equality and freedom. The state must respect, protect, promote and fulfil the rights in the Bill of Rights. Every human being on earth has the right to life. In general, the state's positive and negative duties are set out in section 7(2) of the Constitution of South Africa, which requires the state to respect, protect, promote and fulfil all human rights.

The Constitution of the Republic of South Africa adopted and in 1996 is the supreme law of the land and supersedes all other laws in the country. The main key to having a more eloquent and fulfilling governing system is to align it with the Constitution. This is empirical to developing and implementing health law and policy, which it regulates in at least five important ways:

- It regulates the structure of government.
- It regulates the way in which various branches of government operate.
- It sets out the framework for raising taxes and allocating revenue.
- It guides the content of all laws and policies, primarily through its Bill of Rights.
- It regulates the role of government and non-state actors such as private corporations in realising the right of access to health care services. Furthermore, it emphasizes that every person has the right “to have access to health care services, including reproductive health care”.

The Constitution guides the substantive content of all laws and policies through its Bill of Rights, which it describes as “a cornerstone of democracy”. The Bill of Rights regulates the content of health laws and

[1] *Bill of Rights, Constitution of the Republic of South Africa Act No.108 of 1996*

policies. Therefore, the courts have a duty to directly enforce the Bill of Rights on all. The application of medical science is not exclusive of the such as well, seeing that it has an impact on human life it is indeed justified to regulate it.

The government has a centralized body whereby all resources of the state are overseen and managed. The country 9 provinces in total feeding from that national budget as allocated by the Finance Ministry. This is projected taking into account the statistics and all other factors that may have an impact such as natural catastrophic events or communicable diseases. The economy of the country also plays a huge role in shaping this distribution of resources.

The current healthcare model was intended to be accessible to all members of society. In reality this has not been entirely practical especially in the most needy and remote parts of our country. The supply definitely does not come close to meeting the demand of healthcare services. This has led to extreme levels of discontent by the users and in some way the increase in litigation has been on the rise radically. Ideally this should be a functional structure however there has been multitude of challenges including maladministration, misuse of resources and corruption. I must acknowledge some pockets of progress that has been made and the continued effort to redress.

Pre-1994 the public healthcare system catered largely for the advantaged and left out the majority due to the apartheid laws that were dominant at the time. This has also impacted on constraints that we now see as the services should cover all who require care and unfortunately the planning was less agile. The transition into the democratic government was not quiet the expected and there were teething issues which are still prevalent.

Transformation in my view should not be a flip over nor a quick turnaround, the succession and transfer of critical skills warrant interaction and engagement with the predecessors. This should be rather a gradual calculated rollout of stages which includes pilot studies to mitigate and minimise operational and financial risks. The limited skills and planning led to the demise of most entities within government including the state-owned enterprises. The significant amendment of enacted laws and governance affected service delivery drove some foreign investments. Sustainability of new processes has been evidently poor in some cases as a matter of limited insight and cooperation.

The public healthcare system is currently under scrutiny and remains with a tarnished image and poor consumer confidence. As a result, social unrests and malpractice litigation inclined. The budget speech each year injects a large portion toward the national health department seemingly this is misappropriated. The long-term plan for universal health coverage may not be the only solution given the current state of our economy there is still some corrective exercises to be made.

The National Development plan aims to proceed with the implementation of the NHI by the year 2026 despite the founded concerns and struggling entities. The global researches and guidelines from developed and economically stable first world countries do provide insight into the UHC however cannot translate into a crushing economy and fallen infrastructure. The model that we operate on has to be functional and the data at hand should be an indicator of how prepared the department should be prior to the drastic change. I do not hear of any clean audits in our directorates and customer satisfaction remains a thorn.

The NHI is ideally multifaceted as there are many stakeholders, the funding will impact those actively contributing to the revenue and the economy. Extensive consultations and education regarding NHI needs to occur aggressively to get the buy in from all and also awareness of the benefits. There are expected tax implications with the revenue collection towards the fund. There is limited inclusivity in the targeted cover for our population size considering the large risk pool. According to the plan those who wish to remain on their medical schemes might do so however it will be at a cost. In the plight to achieve equality in provision of healthcare the hope is to create more jobs for balance.

The purpose of the study

The interest in conducting the study was developed after my experiences in employment in both the public and the private sector. I have been placed in advanced state hospitals and clinics during my deployment. I had the privilege of also working vastly in private healthcare as an independent practitioner. As a reflection I noted vast discrepancies and inequalities with regards to the quality and availability of services. The misuse and wastage of resources mostly in public sector and the over servicing by the private sector. The poor and non-compliance of regulatory and statutory policies is also highly significant which made me analytic of the current collapse and what led to it.

The resolutions towards the challenges remain limited and, in some cases, defeated as we have poor customer confidence and generalized discontent. There are efforts being made however the root causes are still not remedied.

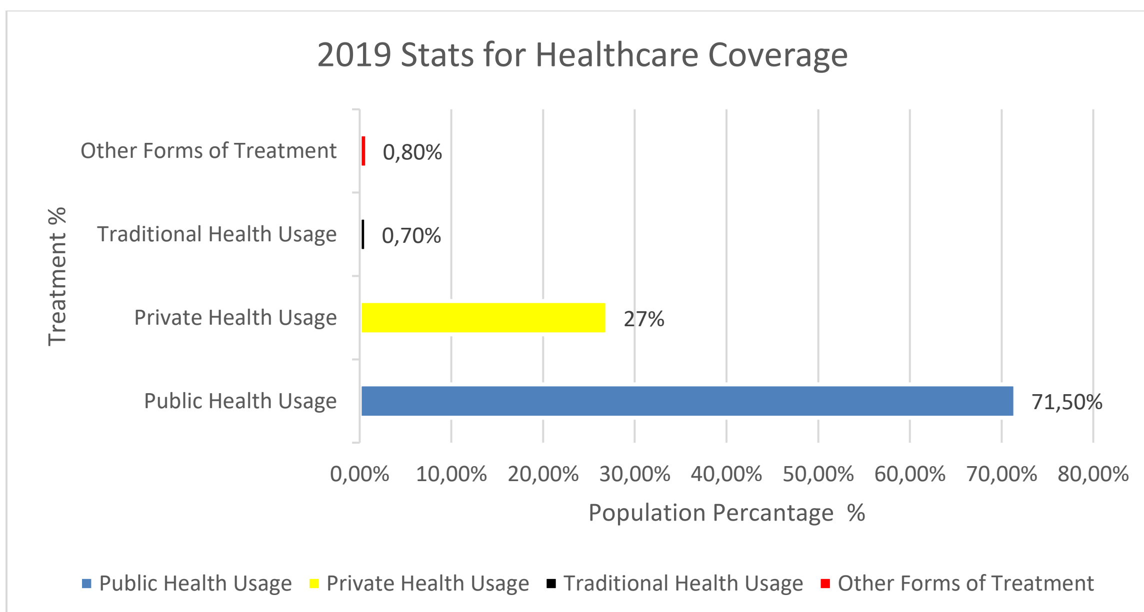
REFLECTIONS

I. According to Sanders and Chopra[2]:

"The implementation of large-scale policies and programs with pro-equity objectives introduced by the new legislation were indeed hampered by fiscal restraints and prioritising technical rather than developmental considerations, leading to rapid worsening of health inequalities in the country. Lack of commitment, competencies and low morale among health care workers further contributed to the poor performance of the public health sector, further increasing the split between public and private care and, in turn, affecting inequalities in health."

figure 1 below distribution of healthcare services versus the population size to date:

Figure 1

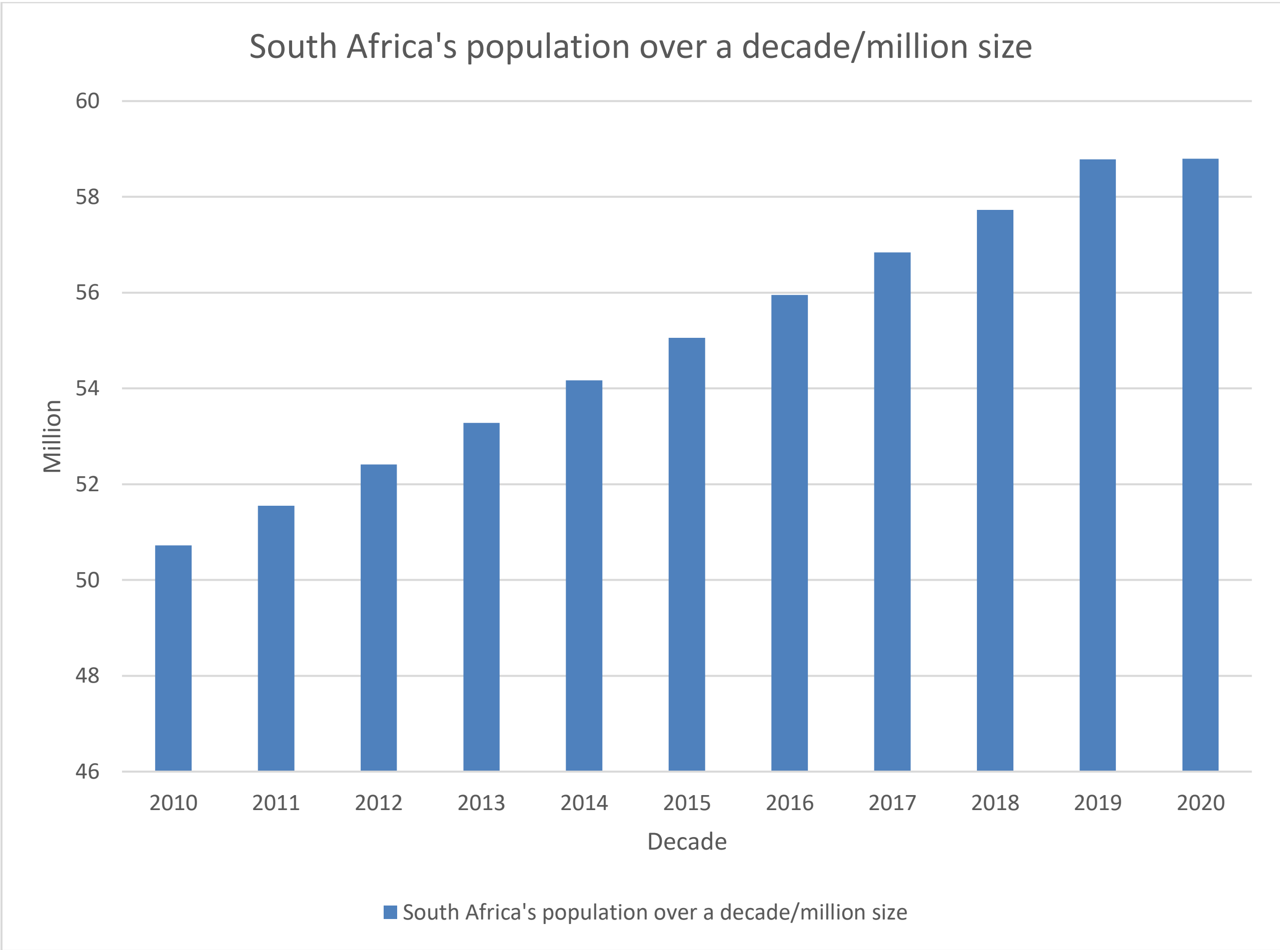


[2] *Sanders and Chopra; Addressing social determinants of health in South Africa (2006)*

Over the years an incline in the population size has been significant, this is due to multiple factors. Others being migrant labourers and asylum seekers who settled permanently in the country, which in turn added to the total population but however towards the growth of the economy.

Gauteng province having the lowest demarcation size compared to the rest of the provinces became densely populated for obvious reasons and this manifested into multitude of challenges.
See figure 2 indicating the growth pattern in the past decade:

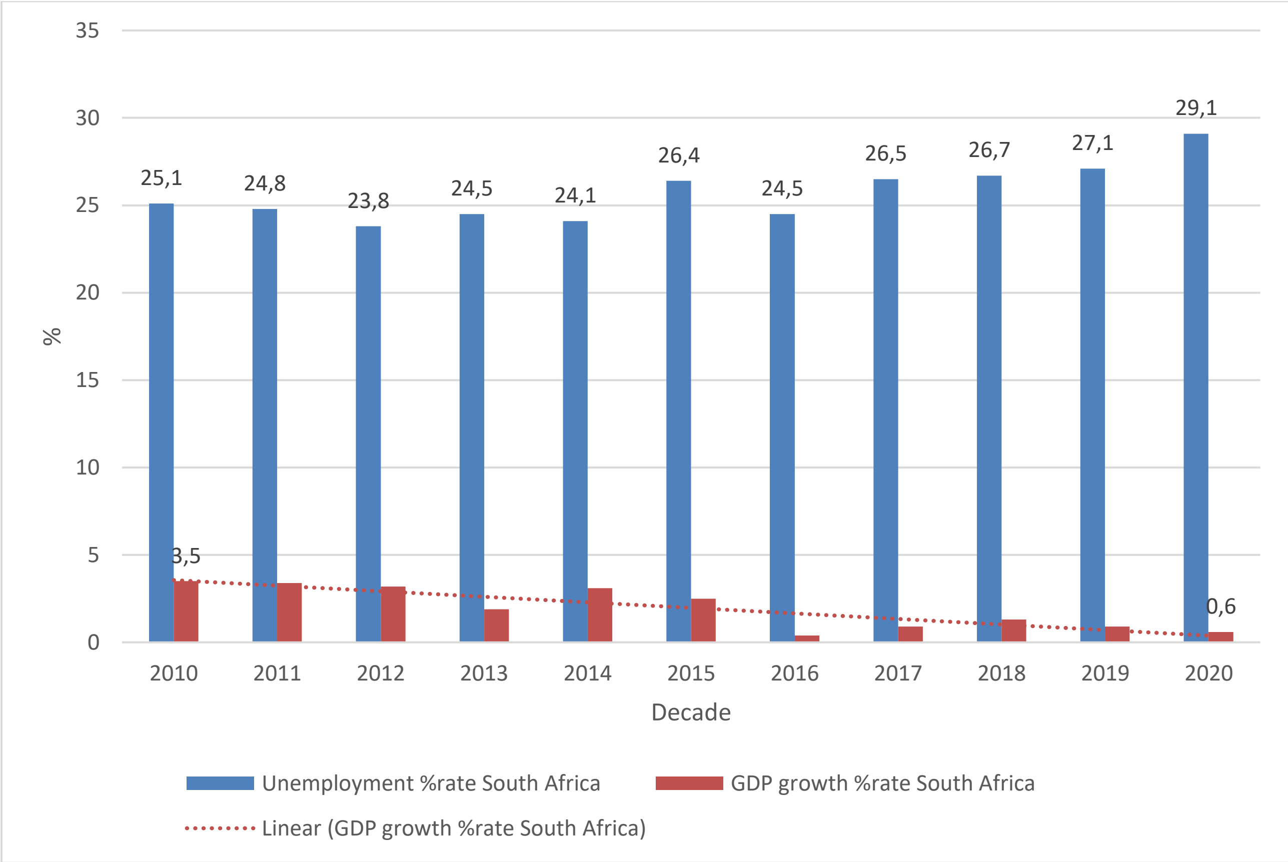
Figure 2



Funding such a massive pool whereas the economy is ailing and faced with junk status possibility by the rating agents is a call for concern. South Africa as of 2019 December is sitting at 29,1% official report of unemployment rate. The GDP growth is now at less than 1% compared to the 2010 growth rate where it was at a competitive high of 3.5%. The state is closing the decade on an economic upheaval. The rise in service delivery protests and our power utility cuts decreases the investor confidence and continues to harm the economy further.

See figure 3 below:

Figure 3



II. History of South Africa

The former government which was in power for decades has had a negative impact on the welfare of the majority in our population. The remnant of the damage is still evident as there is still some correcting of the imbalances of the past. This will be an ongoing process and the state and citizens should allow our new democracy to mature. The shift in our mindsets and our commitment towards unlearning habits and rebuilding the nation should be pledged by all who reside on this land.

Nevertheless, there were low levels of lifestyle diseases back then as opposed to the millennial period. This is ironic because access to healthcare has improved throughout the years. The liberation and emancipation were necessary however it was somewhat a trade-off to some disguised benefits. The majority of our population have become less and less physically active and more reliant on assisted living.

Civilization and evolution contributed immensely to the urban migration in the quest to seek employment and other opportunities. The era condoned high level of physical engagements including prolonged labouring and excessive walking as transportation was also scarce. It was a coping mechanism that also induced disciplined and productive outcomes and as a bonus in money was spent on essential and basic commodities. The noted rise in lifestyle diseases and in pandemics has a direct link to the consequences of poor eating habits and in exposure to addictive substances.

III. **The right to Healthcare**

Access to healthcare is a human right and embedded in Section 27(1)[3] of the Constitution. This right does indicate that you have the right towards the allocated services however it is still your responsibility as an individual to pay for the services provided based on affordability. It further emphasizes that health status is an individual's sole responsibility. This is a dual effort from both the state and the holder of the right. The reality is that the provision and the access to healthcare services should go hand in hand when addressing the resource planning.

Access to healthcare services goes beyond the ministry of health boundaries, it is a global factor. There are other key stakeholders that contributes largely towards the functioning and delivery of health services. The Department of Trade and Industry which has a regulatory duty towards Pharmaceutical Industry for example, as they deal with international trade plays a huge role. Same applies to the Department of Public Works with regards to the actual planning and building of state entities such as hospitals and roads.

Promotion of access to healthcare is so much broader and requires a huge level of focus as the provision of the service itself. Take for example the case of:

Grootboom v S

Grootboom[4] won the case against the state whereby his family was denied decent shelter and dignity. The rights enshrined within the Constitution are obligatory and if contravened the state unfortunately will face litigation. The government cannot act above the supreme

[3] *Section 27(1) of the Constitution of Republic of South Africa Act No. 108 of 1996*

[4] *Grootboom v State (2000) ZACC; Judges Chaskalson P and Langa DP*

constitution or any presiding law of the country. The WHO[5] defines health as: “a state of complete physical, mental and social wellbeing and not merely the absence of disease.”

1994 post-apartheid elections declared free access to public healthcare that created a dependency mentality and somewhat reckless conduct in society which promoted risky behaviours and associated lifestyle diseases. Mental health has immensely increased amongst our society this is mainly due to the socioeconomic dynamics surrounding us.

The is a huge rise in Mental Health Illness[6] within the population ranging from young teenage children to adults. The most common form of response amongst the younger generation is suicide and parasuicide whereas in adults is all forms of clinical depression. Mental Health is rarely regarded as a priority by the health ministry, it is often labelled the orphan of the healthcare system or otherwise non-critical illness.

What is of critical focus for the national department at the moment is illnesses such as HIV, TB, cancer and other life-threatening communicable diseases. The resources are quite restricted within the system as it stands, mental health cannot be the major priority obviously. Although one third of our population suffers from Mental Health Illnesses only 25% might receive treatment with the public healthcare system. There is a forever waiting list to these facilities.

IV. **Burden of care**

Access to healthcare is a right for all inclusive of non-citizens, as is stipulated in the Constitution. The public health care system should ideally cater for all who live in South Africa as a duty. In 2012 the

[5] *Preamble to the Constitution of the World Health Organization signed by 61 states internationally, enforced in 1948*

[6] *SADAG ,21 August 2019 report: The state of Mental Health in South Africa.*

government set a goal to increase life expectancy from 56.5 years in 2009 to 58.5 years by 2014. Graham Anderson[7], the principal officer of Profmed Medical Scheme**,** quoted these statistics in Parliament in 2011. Further it was shown that staff attitudes were sub-standard in 69% of state facilities. This statistic could be the consequence of low morale among staff and burnout, as well as not participating in the organisational vision and mission. Furthermore 55% of facilities did not have the necessary medicines, other supplies and did pass the cleanliness survey and audits.

There are 4 200 public health facilities in South Africa. Since 1994 more than 1 600 clinics have been built or upgraded[8]. The total health spend in South Africa was R248.6 billion, which represented 6.3% of the country's GDP. These figures include contributions by private individuals to medical schemes. The WHO recommendation is that expenditure on the health budget should be 5% of a country's GDP[9]. This means that South Africa is exceedingly over the recommended global budget and yet there is a dysfunctional healthcare system. There are poor controls of budget and distribution of resources.

[7] *Graham Anderson, S.A Parliament report, 2012, Profmed Medical Scheme, Principal Officer*
[8] *Statistics SA ,2018 report on the population and distribution of resources*
[9] *World Health Organization report on Universal Healthcare, 2018*

V. **Training and recruitment of Healthcare Providers**

South Africa trains the largest number of medical professionals in Africa[2], especially specialist doctors and nurses that are highly competent. Better working conditions have led to a greater number of health professional migrating to South Africa. Extending the provision of essential healthcare services to neighbouring states is a challenge as they are dependent on South Africa for primary and chronic care. Migrant workers and asylum seekers also are entitled to free healthcare services despite the financially compromised and under-resourced state.

VI. **South Africa Institutions of Learning Curriculum**

The evolving nature of the education system adds to the challenges. The primary and high school pass rate has fallen, and curriculum standards have been lowered which in turn lead to a lower level of matriculants who qualify for university entrance. On the other hand, tertiary institutions have not lowered their entrance criteria in line with these developments. Matriculants who qualify for medical school entrance are limited in number and some who gain entrance fail to qualify for a medical degree.

Nursing colleges have experienced churn and intake into public colleges has been limited due to curriculum review[10]. Over a number of years there has been a hike in private nursing colleges, some of which are so called illegal institutions. The quality of nursing care has been affected and more care workers than professional nurses are trained. As a result, the capacity for staff retention has narrowed and competition is stiff. The

[10] *SANC, South African Nursing Council, Nursing Act No.33 of 2005*

labour market has become unbalanced and public facilities fail to retain skilled professionals due to low salary conditions and other work frustrations.

A higher salary bracket or increase in incentives alone will not result in the retention of staff in public health systems if working conditions are unbearable. These employed professionals require a conducive working environment accompanied by adequate functional resources. Skilled HCP in remote rural areas are under immense pressure and have very limited or no resources to render health services.
The large portion of professionals prefer employment in urban Gauteng or the Western Cape where there is fair allocation of resources and streamlined processes. Otherwise some healthcare providers seek employment opportunities elsewhere such as in Europe, UK and even Arab countries as opposed to the African continent.

VII. **Medical Universities**

There are medical institutions in the country namely Sefako Makgatho University, University Pretoria, Stellenbosch University, Free State University, University of Western Cape, University of Cape Town, WITS and Nelson Mandela University[11]. The pool of trained doctors arises from these medical schools and some portion from outside the country.

The ties between Cuba and South Africa have become closer in terms of the exchange program and training of students. Cuba has been instrumental in exchange programmes by deploying qualified general practitioners and specialist doctors, which adds value however does not wipe-out these challenges entirely. Recently there is a significant influx

[11] *Higher Education Act of South Africa, No.101 of 1997*

of health professionals from neighbouring states such as Zimbabwe and Nigeria. This has made an impact and has assisted the system positively.

VIII. The Nelson Mandela-Fidel Castro Medical Collaboration

The 21 year-old-collaboration programme adds to the human resource capacity of South Africa's healthcare system[12]. Mid 2017 an estimated 427 Cuban doctors were deployed, mostly in rural health facilities and few in Gauteng Province. 2905 students from South Africa were in Cuba. South Africa trains about 1 200 medical student graduates. The Allied Health Professions Council of South Africa has 3,773 registered complementary health practitioners. The doctor-to-population ratio is estimated at 1 doctor for every 4 219 patients.

IX. Epidemics

An estimated 1.06 million adults and 105 123 children received [13]antiretroviral treatment in 2010. The total number of people living with HIV is estimated at approximately 7,97 million in 2019. The number of people receiving 68%. South Africa has the biggest HIV epidemic in the world, with 7.1 million people living with HIV. HIV prevalence is high among the general population at 20.4%.

South Africa has made huge improvements in getting people to test for HIV in recent years and is now almost meeting the first of the 90-90-90 targets, with 87% of people aware of their status[14].
The country has the largest ART programme in the world, which has undergone even more expansion in recent years with the implementation of 'test and treat' guidelines.

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[12] *Mandela-Fidel Castro Collaboration,1997 initiative*
[13] *Statistics S.A, 2019 Unemployment Report, Parliament*
[14] *Statistics S.A,2019 Report on current HIV/ ARV and Mortality rates*

South Africa was the first country in sub-Saharan Africa to fully approve Prophylactic Exposure Treatment, which is now being made available to people at high risk of infection. This has been a breakthrough in the management of the disease and reduction of deaths. The Treatment Action Campaign and Section 27 has immensely contributed to this success.

***Minister of Health and Others v Treatment Action Campaign*[15]**
The Judgement states:

"There is no rational or lawful basis for allowing doctors in the private sector to exercise their professional judgement in deciding when to prescribe Nevirapine but effectively preventing doctors from the public sector to do so"
This case addresses the challenge faced by a large population of the country whom cannot afford to pay for the Nevirapine to save their lives and those of the unborn. The argument was leaning more towards the protection of the unborn lives as they too are entitled to the free healthcare service. The human life cannot be taken for granted, equality plays a major role in defending those that are helpless and disadvantaged. Being rich does not make your life more worth saving than a poorer person. Same rule applies to the protection of children both born and unborn.

X. Mortality rate

In 2012 the maternal mortality ratio was 310 deaths per 100 000 live births. The infant mortality rate under one year in **2010** was at **41** deaths per 1000 births. The infant mortality rate for **2019** is estimated at **22,1** per 1000 live births. This has improved significantly by almost 50%.

[15] *Minister of health v Treatment Action Campaign (TAC) (2002) 5 SA 721 (CC)*

***Soobramoney v KZN Health Minister*[16]**

The claimant, Thiagraj Soobramoney, suffered from chronic renal failure and was in dire need of renal dialysis in order to save his life the court Judgement found that his case was not an "emergency" in the sense of a sudden catastrophe, but rather an "ongoing state of affairs".
This claimant was unemployed and had no medical aid meaning he had to resort to Public health whereby resources were indeed limited. This is an uphill battle going forward and will continually cripple the public system with continual litigation from users or bearers of the right. The fact remains that the Constitution clearly states that "No one may be refused emergency medical treatment". The defendant argued that provision of health care services is within the confinements of resources which contradicts the protection of the right to life.

XI. **Conclusion**

The most fundamental human right is the right to life which is fought for by the claimant. As for the quality of life thereafter cannot be ascertained beyond the protection of this right. The government is obligated and has a duty towards all who reside in the country including refugees and migrant labourers to promote this right. This is dependent on availability of both human and financial resources and distribution. In terms of Section[17] 27 (3) relates directly to the protection and promotion of life.
There are parts of Constitution that are yet to be tested and stretched. These creates a loophole for public users to misuse or feel entitled to free services and provisions made available through taxpayers.

[16] *Soobramoney vs KZN Health Minister, 1997 (1) SA 765 (CC)*
[17] *Section 27 (3) of the Constitution of South Africa Act No.108 of 1996*

ANALYSIS OF HEALTHCARE

I. Current Healthcare Facilities

South Africa has had its fair share of health burdens in the past as a result of diseases such as TB and HIV and the delay in ARV treatment-rollout added to this situation. South Africans are desperate for treatment options and end up resorting for other forms of care. The open 'street market' provides cheaper and more convenient assistance but is not regulated and has the adverse harmful effects.

Long queues and poor service delivery mean the service that is free to all has become difficult for most of the public users to access. This service should be provided equally without prejudice this includes convicted criminals, those awaiting trial, sex workers and other offenders alike. Exercising freedom of medical treatment choice and autonomy are a human rights issue and should be protected. An informed consent does play a huge role in Medical Law and Human Rights globally, all citizens of the Republic are the bearers of these rights.

Limitation clause of human rights can be overruled by the Constitution as it reigns supreme within the legal system. The case of below is an example of such:

Minister of Safety and Security v Xaba[18]

As much as there is a huge focus on the State's obligations and duties to the bearers of rights, all residents of the country there is also a limitation and restriction of the Constitution which allows informed consent over one's health and refusal of treatment at disposal. We see in this case an inmate refused the bullet to be removed from his leg by a surgical

[18] *Xaba v Minister of Safety and Security and Another (2003) SA 703 (D)*

intervention. Judgement ruled that the proposed forceful act by the minister was an infringement on the rights of the prisoner. He has the right to refuse treatment offered for the benefit of his life, he reserves this wish.

The opposite is the case below whereby the deceased alleged offender was denied emergency medical intervention. The surgeon delayed in providing care and the service overall was delayed miserably which led to his demise. The wife was compensated as the judge ruled in their favour, **Skosana v Minister of Police and Another** [19]

Nasciturus (rights of an unborn child)

II. Pinchin and Another v Santam Insurance[20]

This case law has deemed an unborn child to hold the same rights as a born child. The mother of the unborn claimed for pre-natal damages from the insurance company and subsequently got compensation. What this mean is that all similar preceding cases will use this as a reference for argument. Whatever is on the advantage of the unborn child will be considered, this applies to all pregnant mothers within the system. Given the constraints and poor service delivery by our facilities the department is bound to face an increase in litigation.

III. **Free Public Healthcare**

Whilst on the other hand Public healthcare is even heavily strained with free service provision to the rest of the population. This sector caters for all even patients who have poor scheme coverage. This is a large portion

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[19] *Xaba v Minister of Safety and Security and Another (2003) SA 703 (D)*
[20] *Skosana v Minister of Police 1977 (1) SA 31 (A)*

of civil servants and unemployed to pensioners as well. The very fact that this free healthcare services are entrenched in our constitution poses an obligatory stance to government. This means all who reside in the country should benefit entirely from the system freely. The social unrests and protest are a manifestation of lack of service delivery. Although there are some isolated incidents of thuggery and looting there cannot be a distinction.

Corruption has also contributed to the decay of our healthcare system. Unqualified senior managers and those political deployments and furthermore unwarranted affirmative appointments have really caused uncontrollable chaos within the system.

The healthcare in particular has really taken a deep knock for the worst. I do believe however with the new cabinet ministers there will be a positive shift towards the goals set. The innovative wealth of knowledge they bring will have an impact. Dr Bandile Masuku who is the new Gauteng Health minister, a specialist gynaecologist by profession and an activist comes across as an agent of good change. He is the one of the youngest ministers of health appointed this tenure which may mark a new era.

IV. **The Vicarious liability and litigation**

Public healthcare providers are employed by the Department of Health, a government department. The risk of personal liability for litigation is non-existent as the employer must carry vicarious liability in almost all of the cases. This adds onto the billions of Rands owed to the public which should be funded by taxpayers. This is an ongoing vicious cycle and it really projects a bleak future for our upcoming generation and hardworking labour force.

“In terms of the law of delict, doctors and hospitals are expected to exercise reasonable care to prevent harm from occurring to their patients. Should a patient suffer damage or loss as a result of a doctor or hospital's wrongful failure to take reasonable care, the doctor or hospital may incur liability for negligence. A doctor or hospital that intentionally violates the patient's physical integrity may be held liable for assault, whilst a doctor or hospital that intentionally violates the patient's privacy may incur liability for injuria. The State Liability Act makes provision for delictual liability of the state. Vicarious liability of the state is recognised in that a delictual claim against the state shall be cognisable by a court of law if the claim arises out of any wrong committed by any servant of the state acting in his capacity and within the scope of his authority as such. Both patrimonial loss and non-pecuniary damages are recoverable in delict.” citing **Kovalsky v Krige** (1910); Claassen & Verschoor[21]

In Van Wyk v Lewis[22]

Reference is made to "the general level of skill and diligence possessed and exercised at the time by the members of the branch of the profession to which the practitioner belongs."

What is required, however, is not the highest possible degree of professional care and skill, but reasonable knowledge, ability, experience, care, skill, and diligence. Van Oosten correctly states that the standard that is required: Is thus based not on what can be expected of the exceptionally able doctor, but on what can be expected of the ordinary or average doctor in view of the general level of knowledge, ability, experience, skill and diligence possessed and exercised by the profession.

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[21] *Kovalsky v Krige (1910) 20 CTR 822*

[22] *Van Wyk v Lewis (1924) AD 438*

In Nyathi v. MEC for Department of Health, Gauteng[23]

On July 25, 2005 almost three years later after the incident Nyathi, the applicant instituted an action in the High Court against the Member of the Executive Council for Department of Health (MEC) claiming damages in the sum of R1,496,000 for the pain caused by the stroke and disability suffered as a result of the negligent and improper care he received at the two hospitals. After initially resisting the applicant's claim, the MEC later admitted liability.

Having waited for many months, the applicant eventually received interim payment once he approached the Constitutional Court, but he only lived a short while thereafter. Justice Madala added that "reliance on the State's goodwill and moral standards has in this case proved to be futile." He further made the following pronouncements: An assessment of the cases that have dealt with the Act and the liability of the State for its negligent actions have revealed that courts have been facing immense challenges in this area of the law. The various High Courts have approached the matter very differently and with disparate consequences.

"**However, the common denominator is that judicial officers have recognised that there is a serious problem caused by the fact that a judgment creditor who obtains an order sounding in money, may find that order unenforceable against the State."**

[23] *Nyathi v MEC of Health Gauteng,2008 (5) SA 94 (CC)*

In more recent years, and in particular the period from 2002 onwards, courts have been inundated with situations where court orders have been flouted by State functionaries, who, on being handed such court orders, have given very flimsy excuses which in the end only point to their dilatoriness. The public officials seem not to understand the integral role that they play in our constitutional State, as the right of access.

V. **Compensation Systems**[24]

There is currently no social insurance system for medical malpractice or adverse medical events exists in South Africa. There is also no compensation scheme for criminally caused injuries. Those wishing to recover from private practitioners or institutions have no alternative but to institute proceedings either in contract or delict in a court of law.

VI. **Conclusion**

This is usually a costly exercise and it is pursued by those who have the capacity and financial backing. Awareness of human rights and dignity has been noted and the campaigns by law society including the likes of Legal Aid, Legal Wise, De Broglio Attorneys and Public Protector office.
The cases that are being prosecuted may have been there all along however due to the insight by the public to seek justice and improved access to information it has made them to surface more.

[24] P. Carsterns and D. Pearmain, Foundational Principles of South African Medical Law (2007)

ACCESS TO HEALTH

I. Prof Ames Dhai and McQuoid on access to healthcare:[25]

"Access to health care One of the objects of the National Health Act is to protect, respect, promote and fulfil the rights of the people of South Africa to the progressive realisation of the constitutional right of access to health care services, including reproductive health care. Thus, the National Health Act provides that, subject to any conditions prescribed by the Minister of Health, the state and clinics and community health centres funded by the state must provide:

- pregnant and lactating women and children below the age of six years, who are not members or beneficiaries of medical aid schemes, with free health services
- all persons, except members of medical aid schemes and their dependants and persons receiving compensation for compensable occupational diseases, with free primary health care services
- and women who qualify for a termination of pregnancy under the Choice on Termination of Pregnancy Act, with free termination of pregnancy services.

This is a huge commitment by Government and is obligatory as it is under the Constitution. The services referred to covers a range of illnesses and conditions such as termination of pregnancy and compensation.

The case below is one of a few contributing to thousands of malpractice and medical negligence litigation cases against the state. In 2019 Gauteng Department of Health alone is facing medico legal charges amounting to **29 billion Rands[2]**.

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[25] *Ames Dhai and McQuoid-Mason, Ethics, Human Rights and Health Law;1st Edition (2011) Pages 25 - 27*

Hlatshwayo Agnes N.O and Gugu P Hlatshwayo v The MEC for Health for the Gauteng Provincial Government [26]

The Plaintiff was alleging that the minor child's medical condition (cerebral palsy) was due to medical negligence. It was alleged that the negligence arose during the course of her delivery at the Phillip Moyo Memorial Clinic in Daveyton on the 18th February 2007.
In a well-reasoned judgement, Adams AJ concluded that the Defendant's nursing staff failed in their duty to monitor the mother and foetus, either properly or at all. As such, the Defendant was liable to pay 100% of the agreed or proven damages of the Plaintiff as a result of the brain damage. In respect of general damages, the Plaintiff was claiming an amount of **R3million** on behalf of the minor and the court ruled in her favour. Medical negligence as a causative factor in South African criminal law: Novus actus interveniens or mere misadventure?

S v Tembani [27]

The judge noted that the hospital was under-staffed, especially over weekends, and that the doctor: patient and nurse: patient ratios were woefully inadequate. Judgement quoted that it was indeed:

'a sad experience for me to realise that many of our citizens and members of our society critically injured or wounded might find themselves by dint of their financial circumstances exposed to so woefully inadequate system of medical care'. Judge E. Cameron

It is now well established that a two-stage process is employed in our law to determine whether a preceding act gives rise to criminal responsibility for a subsequent condition. The first involves ascertaining the facts; the

[26] *Hlatshwayo v The MEC for Health, Gauteng,2015, Judge Adams AJ*
[27] *State v Tembani (2006) SCA, Judge E Cameron*

second imputing legal liability. First it must be established whether the perpetrator as a matter of fact caused the victim’s death.

This case almost represents “chronic on acute” scenario whereby there was an intent to murder and subsequent admission to hospital for medical care. The adverse death was meant to occur anyhow it may not be blamed on the latter. It will be difficult to prove the actual cause of the victim’s death seeing that there was a medical intervention aspect. The judiciary should not lose sight of the fact that there was a clear criminal activity which happened to fall in the hands of healthcare providers. It is indeed unfortunate that the state of our facilities is poor and should not be an excuse for not saving lives.

II. Access to public healthcare for COIDA patients[28]

The **COIDA legislation** is underpinned by a set of principles which serve as a guide in the determination of the policy imperatives of the legislation. These principles are outlined below:
NHI funding recommendations
Risk pool profile selection
Inclusion criteria for the disadvantaged

The Constitution and COIDA

The South African Constitution entrenches in section 27(1)(c) the right of every citizen to have access to social security, including, if they are unable to support themselves and their dependents, appropriate social assistance. In terms of Section 27(2) of the Constitution the state must take reasonable legislative and other measures within its available resources to achieve the progressive realisation of this right.

[28] *Compensation for Occupational Injuries and Diseases Act of South Africa, No.130 of 1993*

The compensation of employees for occupational injuries and diseases forms part of the social insurance structure within the social security system in South Africa. Its mandate is outlined in the Compensation for Occupational Injuries and Diseases Act, 130 of 1993, as amended in 1997 The Compensation Fund supports fully the need and purpose for the introduction of the NHI in South Africa. It has given comments on both the white paper and consultative forums

III. **COIDA Benefits**

The benefit structure of COID includes treatment for all occupational injuries and diseases. In the case of disease this stipulation forms part of ILO convention 042, Workmen's Compensation (Occupational Diseases) Convention (Revised), 1934 outlines compensation payable to workmen incapacitated by occupational diseases or in case of death from such diseases. The full list of the diseases to be provided for is listed under Recommended List of Diseases No. 194 of 2010.
In addition, S (66) of COIDA stipulates the following: Presumption regarding cause of occupational disease:
“If an employee who has contracted an occupational disease was employed in any work mentioned in Schedule 3 in respect of that disease, it shall be presumed, unless the contrary is proved, that such disease arose out of and in the course of his employment.”

It is possible that the scope of healthcare benefits provided for under the NHI potentially can be less than that provided for under COID legislation, in that it offers ongoing future medical care to the injured worker for an occupational disease such as silicosis. The worker is entitled to such care throughout their life; in my opinion a crucial benefit and by covering them under the NHI it could contravening the Act and even worse the Constitution. This will then increase litigation and further financial loss to the ministry.

OVERVIEW OF PRIVATE HEALTHCARE

I. Private Healthcare Facilities

Private hospitals operate under prescribed and distinct licences with regard to the rendering of healthcare services and employment of service providers. Healthcare practitioners of specialized disciplines registered with the HPCSA (Healthcare Professional Council of South Africa) are entitled to their independent practice which limits their retention in both sectors. Private hospitals in South Africa are not licenced to employ such scarce skilled practitioners meaning they can only enter into service level agreements with those professionals to render services on their behalf.

Under these conditions they can employ practitioners such as nurses and social workers as they are affiliated or registered with other regulatory entities which permit the practice. These conditions make the system complex and difficult to regulate as there are no fixed terms to standardise agreements for service delivery but there are punitive measures in respect of malpractice or unethical behaviour by practitioners. At the same time, they have to follow the correct channels to impose sanctions.

There are three leading giants in the private health sector which have emerged since 1994: The Mediclinic group providing hospitals and day clinics; The Life Healthcare group offering hospitals and colleges, and Mental Health Units providing day clinics and rehabilitation units.
Licence issues by the Department for private service providers such as The Netcare group, the Busameds Group, Clinix Group and other private health facilities show exponential or steady growth across Africa. There are mine hospitals such as Harmony, Sibanye Gold and the others that are an addition to the healthcare global care system. RMA has opened a state-of-the-art care facility in Welkom, to provide continued services to

the former miners and other patients injured on duty. Sub-acute small-scale health facilities exist as well for screening and support services. There are over 200 private healthcare facilities around the country utilised by minute population due to the cost.

II. Malpractice Insurance

The increasing cost of insurance against medical malpractice suits has spiralled in the last few years, according to Health Minister Aaron Motsoaledi, who in 2015 commented on the problem. He stated that in the eight years between 2005 and 2013, the cost of indemnity insurance for private specialists in obstetrics had gone up by 382%.

The actual amount Obstetricians must cough up on an annual basis has, in the last four years, gone up from **R250 000 to R850 000,** according to Johannes van Waart, president of the South African Society of Obstetricians and Gynaecologists (SASOG)[29]. He added that medical fund tariffs usually increase by about 6% per year, a situation which is clearly untenable for obstetricians. Most South African obstetricians have indemnity cover through the UK-based organisation, Medical Protection Society (MPS), which is registered as a non-profit organisation. It provides cover to obstetricians and other healthcare practitioners.

Pearmain and Carsterns[30] states that: "The relationship between doctor or hospital and patient is essentially governed by private law, and, to be more precise, the law of contract and the law of delict .However, public-law considerations are growing in importance in the wake of the introduction of the 1996 Constitution and national legislation. Any person who is aggrieved by a decision of the HPCSA, a professional board, or a disciplinary appeal committee, may appeal to the appropriate

[29] *Johannes van Waart, president of (SASOG) 2019 Report*
[30] *P. Carsterns and D. Pearmain, Foundational Principles of South African Medical Law (2007)*

division of the High Court. Although courts of law are clearly not bound by medico-ethical codes of conduct and medical practices when determining liability for medical malpractice, the ethical precepts and prevailing practices of the medical profession will be an important consideration in ascertaining what constitutes medical malpractice."

III. Medical Aid Subsidy for civil workers

In recent years the government subsidy of medical aids for employees has been remodelled. This has resulted in most members settling for selected schemes subsidized and thus settled for affordable ones that have limited coverage. The impact has been on employees who are low income earners and only high-income earners would likely afford higher scheme options. The model has its downside whereby unwarranted hospital admissions are on the rise for non-threatening illnesses. This will be in desperation when day to day funds are depleted. It ends up being costly on the side of the employers as the members will be booked off sick regularly. The introduction of GEMS Medical scheme[31] was meant mainly for all civil servants. This is catering for a very large population given that majority of employees are employed by the state. The scheme is also subjected to the Medical Schemes Act

IV. Private Medical Aid Schemes

Medical schemes are obligated to have PMB (prescribed minimum benefits) cover by law. This was introduced into the Medical Schemes Act to ensure that members of medical schemes would not run out of benefits for certain conditions and find themselves forced to go to state hospitals for treatment. These PMBs cover a wide range of close to 300

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[31] *Medical Schemes Act of South Africa, Act No.131 of 1998*

conditions, such as meningitis, various cancers, menopausal management, cardiac treatment and many others including medical emergencies.

At times members are forced to dig into their pockets to cover shortfalls for those bills. It is sad that at any given point public health sector might absorb a pool of privately funded patients for continued medical care. This impacts on the national health budget and puts a further strain on the provision of services.

The many challenges faced by the distribution of human and financial resources by the government has led to an increased demand to utilize the very limited private institutions in a desperate effort to get adequate and somewhat reliable medical services. This obviously comes at a very high cost although it provides comfort and convenience. This situation has led to a high demand for such services and has resulted in immense pressure on those facilities. Having such challenges fraud has emanated and pressure amongst practitioners arose which led to extensive abuse and over servicing reported also by the likes of Discovery Medical Aid.

State v Netcare Kwa-Zulu Natal Limited[32]

This fraudulent activity was meant to circumvent the requirement to gain outside approval, via a Ministerial Committee, for transplants of unrelated principals. While Netcare Kwa-Zulu (Pty) Limited was paid up-front for its participation in the illegal kidney transplants, the people supplying the healthy kidneys were paid after the fact and in cash.

The charges to which Netcare Kwa-Zulu (Pty) Limited pleaded guilty were laid under the South African Human Tissue Act [33] and the Prevention of

[32] *State v Netcare KZN, CCC, 2010*
[33] *South African Human Tissue Act No.28 of 2008*

Organised Crime Act [34]. It might be mentioned that the company escaped charges which had been levelled at the other accused, including fraud, forgery, and assault with intent to do grievous bodily harm (for operations without informed consent). Further, there existed a Ministerial Policy of the Department of Health which set out, inter alia, that:
"Donor organs must be used primarily for South African citizens and permanent residents. Written consent must be obtained from the Minister of Health before any person who is not a South African citizen or permanent resident is accepted onto a transplantation programme."
In my opinion this manifested from the maladministration and corruption by both internal and external members. The pressure to deliver a service and increase revenue might have contributed largely to the fraud. The frustrations faced by the service providers in instances whereby they anticipated what they cannot provide instantly. The process to apply for consent from the ministry is tedious and has been invaded by corruption and bribery. To be on the waiting list itself is a mammoth task. Greed is also another factor seeing that tariff hikes on medical aid funding is too little taking into consideration that this for Netcare is the main source of income.

V. **Medical inflation**

At 10.9% it is almost double the general CPI inflation rate of 5.5%. There are three fundamental drivers of the high cost of medical care:

- New technology
- New facilities opening
- Doctors decisions such as investigations, etc.

[34] *Prevention of Organised Crime Act No. 29 of 2004*

VI. **Best Practised Model**

Discovery medical aid for example has coordinated care programmes for the severely ill patients or terminally ill to manage them throughout their hospital stays and post discharge. For me this is the most excellent type of managed care I came across. If medical funds can be allocated or directed appropriately to serve a specific need then cost saving comes automatically. This includes other extended services such as chronic medication supply, assistive devices and further rehabilitation of any kind. The model really works, as you can see the revenue turnover of this company has been immensely increasing.

VII. **Discovery Health**[35]

Discovery medical aid advocates and motivates members to live a healthy lifestyle through a reward programme. Their product Vitality benefits those who are active in any form such as running, cycling and other various activities that can be tracked. Through this programme you can get a status that even makes you qualify for discounted flights and sporting clothes. They have partnered with most businesses such as Gym clubs for their members to get reduced rates and even gain points for working out. This has got its pros and cons with regards to contributions. This forward strategy has really manifested into other products that generate revenue and adds value to the customers.

Recently they have launched a digital bank that rewards you for saving or having a healthier financial conduct to reap the peak benefits. This basically means that it pays to be money savvy. This is a necessary approach to create awareness to those that may likely be indebted recklessly and instils an investment mentality. Hopefully the upcoming generation will see the value in investment.

35

The world is moving towards the fourth industrial revolution this implies that evolution continues to unfold and should be embraced. The media is consuming the public with reality shows that are influential but yet adding to the spending culture. There is less interest in basic principles such as home cooked meals and healthier habits but rather online shopping and deliveries. Discovery Health has over 331 556 registered members on the Chronic Illness Benefit and in total R1.76 billion was paid for chronic medicine over the past year. This is a reflection of the middle class that can afford medical care meaning the rest of the population on chronic medication is triple.

The brand Discovery

It has extended business in the UK as well whereby they have merged with other brands such as Prudential Life insurance and Standard Life. The brand has significantly grown and signed up with three of English Premier League super clubs namely Arsenal, Liverpool and Manchester teams as an official Wellness Partner. It has even gained the signing of stadium sponsorship rights at AFC Bournemouth. Discovery has offices in Bournemouth and employed 500 staff over there. So being involved in one of the local clubs is part of their social responsibility as well. Over the years Investec the British pioneer has invested into South African sporting clubs and benefited an immense global coverage. In my view Discovery has been following partially in those footprints.

Outcome Based Approach

High performance culture at Discovery Health enhances service delivery which is something our public healthcare lacks. There is absolutely no room for poor performance even, they are focused on daily targets and the vision of the company. The customer service of the company surpasses any other fund in the country currently.

GOVERNANCE

I. Role, objectives and functions of the OHSC[36]:

The OHSC (Office of the Health Standard Compliance) governs health institutions in the country that provides healthcare services across South Africa.

The main focus or objectives of the OHSC:

- To ensure that institutions are delivering on their mandates as stipulated and bound by the Constitution
- Private institutions as awarded licenses prescribed services outlined should be adhered to and malpractice and medical negligence matters prohibited
- Disqualifying or issuing of penalty notices to health, establishments that are poorly performing or below standards
- Exploitation of State funds also monitored and remedied
- Public Health systems management and jurisdiction
- Equality and distribution of resources especially where licensing is concerned
- Inspection of health establishments
- Settling of complaints by the users and recommendations of settlements or penalties informing the Law as the Advocacy of the users.
- Duty to protect and promote safety of users /patients of both public and private health services.
- Ensuring health establishments comply with required standards as entrenched in the Constitution and BOR.

[36] *Office of Health Standard Compliance (OHSC) South Africa, 2019*

- Managing and investigating complaints regarding healthcare services in South Africa.
- Remedial actions or measures prescribed when indicated.

The state requires an office that will stand by its mandate independent of the ministry or political influences, same the former Public Protector Thuli Madonsela who managed to uphold the Constitution and serve the best interest of the public and not of individuals. Accountability is poorly lacking throughout our state departments. This applies to the OHSC as well whereby there has been reports of maladministration and poor leadership, referring to the Esidimeni case.

II. **The functions of OHCS in Section 29 of the NHA should be:**

- Advisory to the minister of DOH on determining the norms and standards that are to be prescribed for the national health system and on the review of such norms or policies
- Monitor indicators of risk for users, any harm posed at users by unsafe and risky establishment to be managed accordingly and action the findings.
- Identification of fraudulent dealings or misuse of resources to be reported and warned to relevant legal bodies

- Make recommendations for intervention by national, provincial or municipal health departments or private health establishments ensure compliance with set norms and standards
- Responsible for publishing relevant health related communications to the public through:
  The media spheres have been adversely affected by the alleged state capture links of Mediosa Clinics, the detrimental occurrences of Esidimeni and Netcare organ transplant sagas respectively. This matter is of high public interest and enlightens and empowers users and

society at large pertaining to the health systems of their country, human rights issues and state funds usage for taxpayers it is of high relevance as well.
Advise the minister regarding quality assurance and management systems matters directly impacting on the national health system, this is for the advancement or improvement of standards for the benefit of the users and their safety.

Issue guidelines to help health establishments implement the prescribed norms and standards, in terms of the National Health Act[37] and similar legislature obtained from the Constitution, BOR etc.
Request and collect norms and standards of all various health establishments and health service users, it is through this process that inconsistencies can be picked up and point of references can be informed.

Liaise with other regulatory bodies sharing common goals and vision, at times to correspond relevant and upcoming health related information for continuous update and new developments, co-ordinate and harmonize regulatory authorities overlapping together with to ensure non-conflicting outcomes and efficient services.

How the OHSC fits into the broader healthcare and medical liability context:

The Ombud for Health Services appointed by the Health Ministry in 2016, is meant to be an independent inspectorate structure although reporting directly to the Minister of health in this regard Health Minister. The functions differ from the Ombud for health professionals for comparison, as it oversees only the health establishments both public and private owned. In terms of health professionals, the HPCSA,

[37] *National Health Act of South Africa, No.61 of 2003*

SANC, Pharmacy Council and other relevant professional bodies are also sharing the same vision but running parallel as they are mainly regulated by different ombud also reporting directly to the DOH ministry. These two entities ideally should be independent supervisory bodies or rather oversight of the DOH functions and healthcare providers as they deal with matters affecting the public.

The OHCS is meant to serve and protect the people of this country without fear or political influences. This entity is a fairly new structure but, in my view, questionable integrity and core function. It seems to me the political syndicates inform the office of what needs to be measured or investigated or reported on which is a total waste of state coffers.

You cannot be your own judge in the interest of serving the public, how objective would that be. Operating under such conditions and dynamics of political influences and abuse of power. With an appalling and crumbling Public Health System measures and turnaround strategies should come from renowned independent Auditors and business analysts or consultants in their private capacity, preferably from other states to give us a somewhat true reflection of our flawed systems and how to resolve issues and put corrective measures in place.

Lawyers have been on the firing line and heavily criticized, firstly with Road Accident Fund for exploiting the Fund and now of late views and opinions coming from the DOH and other stakeholders, claiming that lawyers are opportunistic as perceived and are out there to enrich themselves by Malpractice and Medical negligence litigation cases that are fabricated.

With both this dismally failed state institutions, I hold a different opinion, in fact lawyers have been our saving grace as a nation highlighting the plight of our failures, loopholes self-designed by our

government, costing the country to lose trillions and billions of Rands yearly through corruption, fraud and abuse of resources, which in turn crippled the departments.

The fact that DOH is self-regulating and masking their own inequities by disguises such as OHCS is a vicious waste and leaves a lot to be desired. A department of that magnitude should be highly scrutinized, and performance managed privately for outcome-based measure purposes that are reliable. Instead they want to pursue NHI as an initiative to cover up in disguise. The clear conflict of interest from this office compromises its integrity.

The ombud or public protector for healthcare users will investigate and determine liability in cases of litigation or malpractice by the health establishments It should acts as a buffer between the users and the state or private owned health establishment in the best interest of the user always. If in so doing it surfaces that individual practitioners are held liable the Professional ombud will step as a regulator for health professionals affiliated to different bodies.
Both ombudsman outcomes and findings that are legally implicating may be redressed through the office.

HPCSA

This is an oversight for all practicing healthcare and allied professionals in the country. There are immense political influences and dynamics within parastatals and other state-owned entities. There is a critical need to address these challenges and eradicate corruption from the roots at all cost. The damage might not be reversed however it needs to curb for the purpose of preserving and protecting the rights of vulnerable patients.

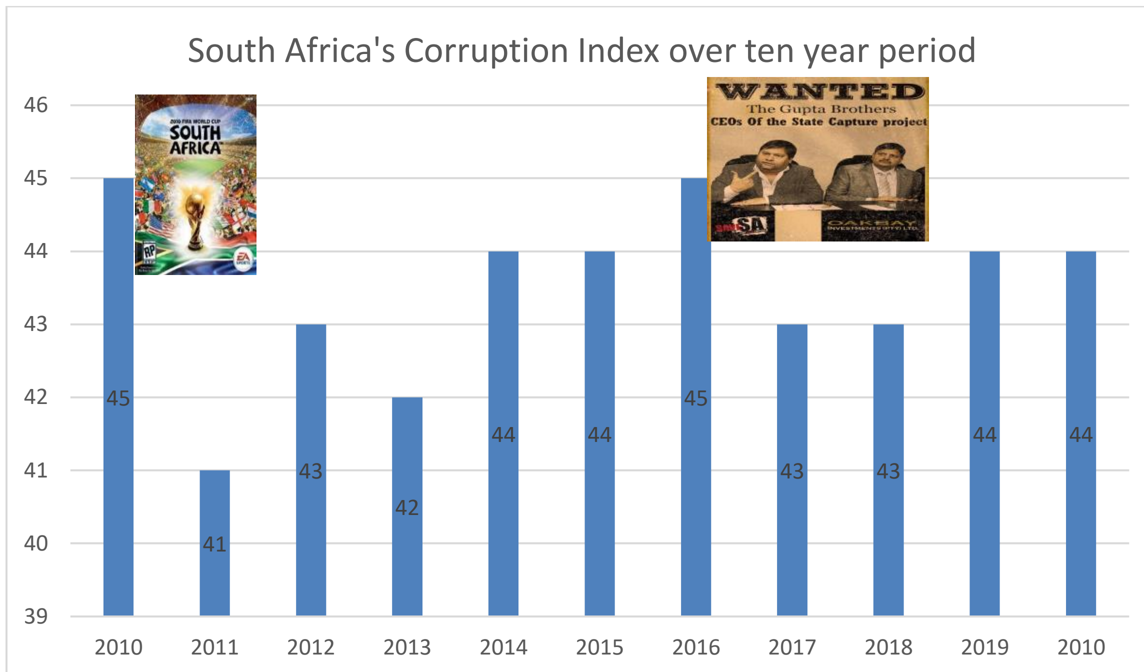
Licencing

Practices in the regulation and issue of licenses by the department of health are highly questionable. The growth in private facilities is restricted to the more prosperous provinces, which some view as indicating that the practice continues to favour the wealthy. It is proposed that health resources be decentralised in distribution in preparation for the launch of UHC and be inclusive of neglected regions. The quality of healthcare has declined drastically, especially nursing. This situation is linked to understaffing matters and the failure to train sufficient qualified registered nurses with specialist skills.

III. Political Influences

It is imperative to have good and principled leadership for ensuring ethical governance within the department. This also serves as to reassurance towards the subordinates. The focus will be to the benefit of the country and not individual's interests. The syndicates or cliques of corrupt leaders also deprives and discourages some to even influence change.

The poor and helpless will forever remain marginalized if no radical change is taken. See figure 3, Corruption index in South Africa:
Figure 4



How can we ever forget the booming in economy through the soccer world cup coupled with tender corruption for infrastructure developments, the nenegate, the state capture and other highlights during President Zuma's turner.

The onus rests upon us as a nation to appoint the appropriate candidates in offices of power who will heed the call to clean out corruption and remain ethical in doing so. There has been some hope and a shift in the mindset of our people. The ruling party has lost a vast majority of voters leading to the opposition parties are gaining popularity.

The leaders of our state have not optimized such a brilliant democratic manifesto at their disposal by not ensuring good leadership and governance when it comes to implementation. Although policies and frameworks are available and adopted there has been poor effort to see

them pass. The country is in more than 25 years post-apartheid and yet the shift to better living conditions is minute.

Medical law and health care law in South Africa have become significantly more complex of late. There have been many recent legislative changes which have materially altered the law governing both the funding and delivery of health care as well as the general understanding of medical law in this country, and there are more such changes to come. For example, a complicating factor in the legislative arena is that, in terms of Schedule 4 of the Constitution of the Republic of South Africa, each of the nine provinces has legislative competence in the area of health services (P Carstens, Pearmain, 2007).[38]

People in rural areas are also more dependent on public health care than private health services compared with urban dwellers, leading to urban-rural inequalities in access to health care across the country which often discriminate against the poor (Booysen 2003)[39]. The challenges faced by the country requires every responsible citizen contributing towards the economy to contribute towards the resolutions.

IV. **Outcomes and campaigns**[40]

The South African response has been positive, and it has the most extensive ARV and TB rollout programmes worldwide. The rate of infection has been lowered significantly, particularly in the younger population group. South Africa's National Strategic Plan for 2007 till 2011 Is the reference for the fight against HIV, TB and STIs.
The African continent looks to South Africa to lead in the campaign against these diseases. Other life-threatening conditions, including

[38]*Foundational Principles of South African Medical Law, P. Carstens and D. Pearmain (2007)*
[39] *Booysen, Urban-rural inequalities in health care delivery in South Africa (2003)*
[40]*Section 27 & TAC; Treatment Action Campaign,2010*

‘lifestyle’ ones such as type 2 diabetes mellitus and cholesterol, are on the rise and are a challenge to manage.

A preventive rather than curative approach such as for HIV/AIDS/TB is most likely to be successful. Exercise and the promotion of a healthy way of life should be encouraged and rewarded. This policy could result in financial savings for a limited budget. Nationally and provincially our public health system is ailing; most experts say it requires emergency resuscitation.

NHI FUND:

The NHI Fund (NHIF) proposes to function as a Schedule 3A public entity and will be governed by the NHI Board that will exercise oversight over the entity. The NHI Board will report to the minister of health and will be accountable to parliament. The NHI Board will not be a stakeholder representative body but a Board with a specific mandate to ensure the NHIF is functional, effective and accountable.

The composition of the NHI Board will be based on experts in relevant fields, which may include healthcare financing, health economics, public health, health policy and planning, monitoring and evaluation, epidemiology, statistics, health law, labour, actuarial sciences, taxation, social security, information technology and communication. The Board also will include civil society representatives.

The Board should consult extensively with public and private users and service providers, including medical aid schemes as they are major stakeholders. It is an unrealistic idea to isolate and also potentially infringe on the rights of others who wish to remain privately funded.

There should be clear guidelines as to how all the funders will be incorporated within the NHI. If they are side-lined or excluded, it will negatively impact on the lives of many injured employees.

This benefit needs sensitive attention as it protects the rights of both employee and the employer. The employee gains a waiver from many forms of litigation by compliance with the Compensation Fund or Department of Labour. A weakening of the commitment by either party would see a massive increase in litigation. This benefit protects their rights to work in a safe and healthy work environment that is regularly inspected. There is a newly amended bill awaiting adoption by parliament which will be possibly enacted in 2020.

I. NHI Model

Three fund types are available:

1. Private sector: Medical Aid Schemes estimated at 20 million members funded by tax credits and employer and employee contributions
2. Public Sector: Medical Aid Schemes estimated at 5.5 million members funded by tax credits and employer contributions.
3. New NHI Fund estimated at 30 million members funded by allocations from general taxation

II. Information Management System

Data collection in public facilities is an ongoing battle given the volumes of patients administered to daily. To keep records of such magnitude and confidentiality is a challenge bearing in mind the human capacity at state facilities. Private facilities, on the other hand, are bound to excel in this regard due to the fact that they depend on invoicing the medical aids and other funders for revenue collection. This function is impeccable otherwise they will run at a loss.

Currently these two systems do not share data unless as per referral, which means there could be duplication of records and over-servicing of patients throughout facilities as patients can move from one facility to the next and interchange to facilities in other provinces as well. This possibility poses a risk of drug wastage in exposure to chronic patients as there is no monitoring of health records. Data management systems should be designed to integrate countrywide. This solution will enable service providers to track and monitor progress and wastage. Also, it will assist in preventing financial losses.

III. Recommendations

It is proposed that the NHI Bill accommodates the unique benefit structure of COID as currently it is of great benefit to employees. A possible option is to consider a 2-tier benefit structure, namely a general structure for the population and the additional benefits unique and specific to COIDA for all employees as a top-up.
RAF has a valuable future medical-care benefit programme which can be copied or referenced within the proposed NHI since it is well structured and functional. The pay-outs they provide clients do not impact other benefits which, I think, adds value to the positive quality of life. RAF pays for a caregiver for life and offers placement facilities for severely affected or disabled patients who require a high level of medical care. This practice alleviates the pressure on family members who are caring for their loved ones.

IV. CONCLUSION

- NHI has an excellent long-term objective that might alleviate the situation arising from healthcare challenges. If it is properly planned and executed, it might achieve the desired outcome to the benefit of all and be cost effective. The funding issues need to be addressed and measures be put in place to ensure its sustainability. Also, revenue collection must be well regulated.

- The SLA between service providers and government entities should be honoured and conducted ethically and lawfully. The management of fraud and the prevention of the waste of resources are essential items and offenders must be penalised.

- Responsible and accountable stakeholders should oversee the NHI and hold task team members accountable for any misconduct or irregularities observed.

- PPP (Public Private Participation) should be sufficiently conducted throughout the country to derive valuable inputs. To be avoided is a one-sided resolution such as the **E-Toll** pay system in Gauteng Province.

- This massive project should not be viewed as the only solution to the problem but rather is an option that could work if well-executed and co-ordinated.

The majority of scholars think the funding model is non-existent and will create a duplicate tax to income earners in that they will subsidise the poor and non-participants in the economy at the same time that they pay for their own healthcare.

The state of the DOH nationally in terms of budget expenditure raises a great deal of concern because there has been poor management of funds and other resources in the past ten years. The department never has stayed within budget in fact they receive additional payments from other departments that under spend on their budgets. It is a cause for concern if the minister who proposes a project of such magnitude has failed over two terms to present clean audits and to have a stable department.

In my view NHI is a problem adding to our existing problems. At this stage it cannot be a viable option. Perhaps if the public sector has recovered from its ICU status then it will be possible. It is a concept appropriate to less corrupt and more developed states that have better measures in place to regulate their systems.

If the head of health can perhaps refer to a mode like Discovery Health as an aid to administer NHI this could possibly minimise inherent risks and other threats. There is a dire need to redress and align processes better and roll out the pilot in phases that are not aggressive.

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