National Health Insurance (NHI) – towards Universal Health Coverage (UHC) for all in South Africa: a philosophical analysis

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Declaration of academic integrity

I hereby declare that the composition of this dissertation entitled: "National Health Insurance (NHI) – towards Universal Health Coverage (UHC) for all: a philosophical analysis," is my own academic work and that the dissertation has not been submitted at any other university and where other authors in this dissertation have been either quoted or paraphrased, this has been thoroughly referenced.

Mbhekeni Sabelo Nkosi 28 February 2020

To my loving parents

Tinkie T. Nkosi and Earnest P. Nkosi

Ngiyabonga Nkosi, Dlamini, beluhlanga lakwaNgwane, enibahle kakhulu, s'dlubuladledle saka Lobamba, sona lesitsi nasibapha sibe sibadlubuludlisa, gwalagwala lelihle lemakhosi, samketi sakucala sinembovu emalangeni, sidvwaba silutfuli, singebantolo sifute ekhabo nyoko, nina abakwa Nkosi! Dlamini! Enabophela lokuhle emfuntini nentela bafati bete kuhawukela, nina enikhothwayo, bekunene, Mntungwa, ludonga luka Mavuso, enacedza lubombo ngok'hlehletela, eningayidli imvu nesaba emafinyila nemcondvo, Ndlovu ezidlekhaya ngokuswela abelusi, Sibhahuza sika Mawawa, Ngwane, Hlubi lomuhle, Mlangeni, Sobhuza, Mswati, Wawawa.

Abstract

This study is a philosophical analysis of the National Health Insurance (NHI) policy and legislation, including the related NHI Fund, with a view to assessing its prospects in realising Universal Health Coverage (UHC). The NHI system is about ensuring universal access to quality healthcare for all. The rationale is to provide free healthcare for all at the point of care/service. This legislation has the potential to transform, on the one hand, the relationship between the public and private healthcare sectors and, on the other, the nature of public funding for healthcare. Part of the challenge with the NHI system is that it seeks to provide healthcare for all, but by seeking to integrate the private sector it runs the risk of commercializing healthcare.

The study is philosophical in that it holds that ideas have consequences (and conversely actions have presuppositions with certain meanings). In part, it aims to show that an implementing mechanism of the NHI system as presently envisaged has socio-political and economic implications with fundamental contradictions within it; for it seeks to incorporate the private healthcare sector in offering free public healthcare services. This introduces a tension for private healthcare services operate with a neoliberal outlook and methodology which is at odds with a public approach that is based on a socialist outlook. The analysis may make explicit conceptual and ideological tensions that will have practical consequences for healthcare.

Much of the commentary on the NHI system have focused on the practical consequences for healthcare; my intervention is to explore and critically assess the various philosophical assumptions that lie behind these practical concerns. Some of these practical consequences are related to the possibility that healthcare is likely to become commercialized and the public healthcare sector will remain in a crisis. This study argues for the provision of access to high quality healthcare facilities for all members of the South African population. Healthcare must be provided free at the point of care through UHC legislation or by the setting up of the NHI Fund as financing mechanism.

The study provides reason for the decommercialization of healthcare services completely – that is for eliminating private healthcare from contracting with the NHI Fund. Essentially, it argues for the claim that healthcare should not be traded in the market system as a commodity and that the NHI system in its current incarnation seeks to do precisely that. I further argue that in theory and in practice the neoliberal and socialist assumptions underlying the NHI system in its present formulation do not fit together. On the contrary, rather than a two-tiered system incorporating the private and public healthcare sectors, the dissertation argues for a different way of conceptualizing the NHI system that privileges the latter.

Table of Contents

Key Terms

Healthcare

Neoliberalism

Dialectical Materialism

National Health Insurance (NHI)

Universal Health Coverage (UHC)

Chapter 1

Background – the emergence of a problem

1.1 Introduction

The South African government issued a Green Paper (August 2011) on the National Health Insurance (NHI) and consequently, after four years, published the NHI White Paper (December 2015).[1] Terms of reference for the 6 NHI Workstreams were gazetted on 11 December 2015 [(in terms of Section 3(1)] of the National Health Act, 2003 (Act 6 of 2005). A revised NHI White Paper was issued out in June 2017. The NHI policy and legislation seeks to introduce Universal Health Coverage (UHC) in the South African healthcare system. The NHI Bill, which legislates for the formation of the NHI Fund, was gazetted by the government in 2018. According to the NHI Bill (2018), UHC means that,

> [All] people [shall] have access to promotive, preventative, curative, rehabilitative, and palliative healthcare services that they need, regardless of socioeconomic or healthcare status, where such services are of sufficient quality to be effective, and that people should be financially protected from the costs of using such services.[2]

The NHI Bill (2018) suggests that all people in South Africa shall have access to the healthcare services that they need "regardless of socioeconomic or healthcare status."[3] The health services covered by the NHI will be provided for "free at the point of care."[4] This means that all citizens and non-citizens will be able to access healthcare services for free. The concept of free

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[1] The Department of Health (DoH) published a Green Paper on the National Health Insurance (NHI) in August 2011. The decision was followed by the adoption of the National Development Plan (NDP, 2012) and congress resolutions from the African National Congress (ANC)'s 53rd Conference. Both the NDP and the congress resolutions argue for the NHI. The National Planning Commission (NPC) according to the NDP (p.344) supports the broad principle of universal healthcare coverage outlined in the Green Paper on the NHI and the process is under way in government to investigate the most appropriate mechanisms for financing the NHI. The success of the NHI in South Africa will depend on the proper functioning of the public healthcare system. The Commission supports attempts to improve the public healthcare system, starting with the auditing of facilities and setting appropriate standards. The White Paper on the NHI was issued out in December 2015.

[2] *Draft National Health Insurance (NHI) Bill* (Department of Health: republic of South Africa, 2018), 10.

[3] This is interpreted in various sections of society to mean free healthcare for all, including equal access into all healthcare facilities without a cost to any user.

[4] *White Paper on National Health Insurance (NHI) for South Africa – Towards universal health care coverage*, Version 40, (Department of Health: Republic of South Africa, Thursday, 10 December 2015), 9.

healthcare for all in South Africa is historically and philosophically underpinned by a socialist ideological system.[5] As a result, healthcare services that are offered by the South African government in public hospitals are free.[6] However, in the private healthcare system, healthcare is inaccessible for the majority and too expensive for the poor. The private healthcare system is underpinned by a neoliberal ideological system. Healthcare in such a system is not free, it is paid for at an expensive cost. Generally, capitalism structures the social order of South African society. Therefore, UHC is about financial protection from the costs of using private healthcare services. Hence, the government is developing an NHI system that includes a financing mechanism (NHI Fund) that will act as a strategic purchaser of healthcare services in the private healthcare system (in this case there is a purchaser-provider split). Yet, the government is already purchasing healthcare services from itself on behalf of the population (where the purchaser is also the provider). Thus, the strategic goal of the NHI system is to ensure free healthcare services for private healthcare system users (paid for by the government) through the NHI Fund as a financing mechanism. In doing this, the government intends to offer free public healthcare services to the population using private healthcare institutions (the concept of public healthcare services through private sector delivery).

The issue is that the NHI policy and legislation seeks to introduce universal health coverage (UHC) into the healthcare system that attempts to combine public and private healthcare systems which operate, I argue, on the basis of *(a)* incompatible ideologies and *(b)* contradictory mechanisms. The main intent of the NHI Bill which introduces UHC is to provide free universal healthcare through the formation of the NHI Fund. The problem arises, I hold, when UHC is implemented by using a financial mechanism – the NHI Fund – to purchase private healthcare services (i.e. pay private healthcare facilities) so as to enlarge its capacity to provide healthcare.

The dissertation concludes with an analysis of the NHI system's approach and the question of community healthcare workers. It calls for a strategic reengineering of primary healthcare.

[5] The concept of free healthcare for all in the population is underpinned by a socialist ideological system. However, in a conversation with Prof Robert Van Niekerk it appears that the ideological system that underpins it lies more with social democracy not socialism or communism. I contest Van Niekerk's position. I take a position that democracy was the goal for the first phase of the South African liberation struggle. The second phase is socialism. The challenge is political strategy.

[6] In my view, the alliance partners of the African National Congress (ANC) shift the ANC to the Left, though the ANC maintains a neoliberal ideological posture.

1.2 Brief historical and policy background

At the 52nd National Conference of the African National Congress (ANC) which was held in Polokwane in December 2007, the ANC adopted a resolution to implement the NHI system.[7] The ANC then instructed its National Executive Committee (NEC) to take forward the task of implementing the NHI system.[8] The ANC has committed, in many policy areas, to universal access to quality healthcare. However, universal access does not only mean that the state shall provide free healthcare, but that the state shall also play a regulating and directing role in the healthcare sector, though in certain circumstances. This means building social consensus with the private sector, to ensure free access to private sector healthcare facilities for the poor and the working-class. In this instance, the expectation is that the state shall play a consciously redistributive role, as in the case of providing access to free healthcare through the NHI system.[9] The mandate that has been given to the ANC includes the ten (10) Point Plan to transform the South African healthcare system, the centerpiece of which is the implementation of the NHI system.[10] The Congress of South African Trade Unions (Cosatu), an ally of the ANC, has supported the ten (10) Point Plan as adopted by the National Department of Health (NDoH).[11]

In the year 2012, the ANC noted that South Africa spent 8.5% of its Gross Domestic Product (GDP) on healthcare, split roughly 50:50 between the private sector and the public sector. The private sector provides healthcare for eight (8) million South Africans with private medical insurance, and the public sector provides healthcare to the remaining roughly forty two (42)

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[7] In 2009 the Minister of Health, Aaron Motsoaledi, established a ministerial advisory committee to advise on the development of policy, legislation and implementation of the NHI. The Government Gazette (11 September 2009) points out that the introduction of a National Health Insurance System is founded on three principles: (1) It is a Constitutional right that the public has access to affordable and acceptable quality health services; (2) It is the responsibility of the State to ensure the progressive realization of the right to health for all South Africans that is premised on the objective of universal coverage; (3) It is important for health services to be funded in an equitable manner that promotes social solidarity (Department of Health, 2009).

[8] Cosatu, 12th National Congress, Discussion Documents: Book 5, (2015), 40.

[9] African National Congress (ANC), 'The Second Transition? Building a national democratic society and the balance of forces in 2012: A discussion document towards the National Policy Conference,' Version 7.0 as amended by the Special NEC (27 February 2012), 10.

[10] Cosatu, 'A growth path towards full employment: Policy perspectives of the Congress of South African Trade Unions,' (Draft Discussion Document, 11 September 2010), 88.

[11] Cosatu, 'A growth path towards full employment: Policy perspectives of the Congress of South African Trade Unions,' 88.

million people who are without private medical insurance.[12] The current variables at play are that approximately four and half percent (4.4%) of GDP is spent on sixteen percent (16%) of the population, due to the high cost of healthcare in the conglomerate private sector. The remaining four percent (4.1%) of GDP is spent on eighty four percent (84%) of the population (mainly the African poor majority and working-class population in the country), due to the relatively cheap cost of public healthcare compared to the private healthcare sector.[13] While overall spending as a percentage of GDP is comparable to most European Union (EU) countries, it conceals the huge disparities between private and public sector spending per capita (R11, 150 versus R2, 766).[14] According to the ANC National General Council (NGC, 2015), the NHI Fund had not yet been set up using state revenue; the resolution directed that the fund be set up urgently.[15] Discussions were initiated between the Department of Health and the National Treasury through the facilitation of the Presidency.[16] The Presidency (through its national youth policy) states that,

> The country's NHI funding model will give effect to the three key principles of the NHI: [i] universal provision of quality healthcare, [ii] social solidarity through cross-subsidization, and [iii] equity. For this to happen, [the] government will pass the NHI Act in the next five years, finalize the funding model for the [NHI Fund] (including budget reallocation for the district primary healthcare [*sic*] and personal health services) and create the [NHI Fund] by 2016/17.[17]

To ensure universal access to quality healthcare a publicly funded and administered NHI Fund will be established to drive the roll-out of the NHI system. The government intends to pass the NHI Act and to finalize the funding model for the NHI Fund. Its claim is that the NHI policy and legislation, which aims to create a single (*unified*) healthcare system over twelve (12) years (2012 to 2025), shall greatly increase demand for quality healthcare facilities, medicines and

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[12] This point is also noted in the *Industrial Policy Action Plan (IPAP) Economic sectors and employment cluster: 2014/15 – 2016/17* (Department of Trade and Industry), 93.

[13] According the NHI White Paper (p.17), "South Africa spends 8.5% of GDP on health and 4.1% of the GDP is spent on 84% of the population, the majority utilizing the public health sector whilst 4.4% of its GDP is spent on only 16% of the population in 2015/16."

[14] *Industrial Policy Action Plan (IPAP) Economic sectors and employment cluster: 2014/15 – 2016/17*, 93.

[15] African National Congress (ANC), *National General Council (NGC) Discussion Documents*, Special Edition, (ANC: Umrabulo, 2015), 103. The ANC NGC shall be held again in 2020 to discuss progress regarding the resolution.

[16] African National Congress (ANC), *National General Council (NGC) Discussion Documents*, Special Edition, (ANC: Umrabulo, 2015), 103.

[17] *National Youth Policy (NYP)*, (Presidency: Republic of South Africa, 2015-2020), 24.

medical devices.[18] Consequently, the Ministry of Health is embarking on massive reforms, covering health systems, personnel and financing, among others. The policy and legislative proposals presented in this study are in line with many of the strategies that are under consideration with the Department of Health (DoH).[19] It is important that the policies of the DoH be fully harmonized with various other departments and coordinated in order to transform the current growing economic burden into an opportunity for the South African economy.[20] But, how does the South African government justify the use of public funds through the mechanism of the NHI Fund to offer public healthcare services to the entire population using private sector institutions? The significance of this question must be understood against the following background.

There remain gross internal inequalities within the healthcare sector which are both structural and racialized due to the dichotomy between the conglomerate private healthcare sector and the public healthcare sector. These inequalities and disparities have both race and class dimensions. This means that the majority of private healthcare facilities, private clinics and hospitals are in former whites only areas. Therefore, a racialized, neoliberal, and ideological approach to the NHI system poses a structural problem to the realisation of quality healthcare for the poor and working-class. Free healthcare at the point of service, as the NHI policy and legislation proposes, can be undermined by the commodification and commercialization of healthcare in South Africa. There remains a threat that the NHI system may end up being unjustly biased to procuring quality healthcare services from the conglomerate private healthcare sector due to its structure as a financing mechanism. The NHI White Paper (2015) asserts that,

> Population coverage under [the] NHI will ensure that all South Africans have access to comprehensive healthcare services. This means that people will be able to access healthcare services *closest to where they live*. The healthcare services will be accessed at the appropriate level of care and will be delivered through certified and accredited public and private providers using [the] NHI Card (italics added).[21]

[18] *Industrial Policy Action Plan Economic sectors and employment cluster: (IPAP) 2014/15 – 2016/17*, 93.

[19] *National Development Plan (NDP) Vision 2030: Our future – make it work* (Presidency: National Planning Commission, 2012), 330.

[20] *Industrial Policy Action Plan (IPAP) 2014/15 – 2016/17*, 93.

[21] Department of Health, 'White Paper on National Health Insurance (NHI) for South Africa – Towards universal health care coverage,'1.

The majority of people in South Africa live in the rural areas, townships, and squatter settlements (shacks). From a race and class perspective, and within the context of racialized inequalities and racialized spatial disparities, the majority of people in the country are unable to access healthcare services *closest to where they live*. Healthcare facilities, for many, do not even exist in their communities, particularly in the rural areas. Most private hospitals and private clinics are non-existent in various townships and villages in South Africa, including the squatter settlements. This structural reality poses a challenge with regards to the majority of people accessing healthcare services "at the appropriate level of care" and such services being "delivered through certified and accredited public and private providers using [the] NHI Card." Notably, the NHI White Paper (2015) suggests that healthcare services shall be delivered through public providers. Yet, it simultaneously submits a proposal that public healthcare services shall be delivered to the public using private healthcare institutions.

Effectively, the current understanding is that the NHI Fund sets up as a giant "medical aid fund" and will issue out to all a "medical aid card" (NHI Card). Cosatu raised a concern [in its Secretarial Report (2015) to its 12th National Congress] regarding the NHI Fund functioning as a medical aid cover. According to Cosatu's Secretarial Report, the General Household Survey (GHS) of 2003 indicated that,

> [Only] 8% of Africans had medical cover in 2003, while 65% of their white counterparts had access to medical aid. The GHS of 2012 indicated that the situation had not changed. According to [its] report, only 10.4% of the African population had medical insurance and 75% of the white population was on medical aid … [the survey] revealed that most of the African population is dependent on the public sector. White citizens use private doctors, clinics and hospitals. [In 2003] 63.4% of the Africans used public health services; while 84% of the white citizens used private facilities. Econex's (2013) study of [South Africa's] private healthcare sector reveals that it accounts for 50% of the total expenditure…[yet] it only supports 16% of the population. Most South Africans (84%) are dependent on 47% of the nation's health expenditure.[22]

In view of the above quotation, Cosatu has constantly argued that the only practical and justifiable solution is the introduction of the NHI system. However, should the entire national healthcare budget not be spent on the public healthcare sector *only*, for its improvement; and

[22] Cosatu, '12th National Congress: Political and Socioeconomic Reports,' Book 2 (Secretariat Report, 2015), 175.

for the building and construction of key healthcare infrastructure; and the recruitment and training of human resources for health (HRH); to the benefit of the majority in the population that do not have access to healthcare facilities? The creation of a single strategic fund to decrease the financial risks that are associated with accessing healthcare must be to the benefit of all people that use public healthcare facilities, more especially patients that reside in the villages (rural areas), townships and the squatter settlements that ordinarily would not have access to quality healthcare. The public healthcare sector is currently under-resourced and desperately needs to be improved where it exists in certain areas. Public healthcare systems may need to be built in areas where they do not exist. Yet, through the NHI system, healthcare services shall be procured in the private healthcare sector on behalf of the entire population; this will lead the state into an intractable problem.

1.3 Statement of the research problem

Due to the high cost of healthcare in the conglomerate private healthcare sector, South Africa spends 8.5% of its Gross Domestic Product (GDP) on healthcare. The main problem has to do with the commodification and commercialization of public healthcare services. This is underpinned by a neoliberal ideological system of healthcare provision through private healthcare institutions for profit maximization. There is an ideological problem in the government's offering of free healthcare services to its population through the private healthcare system and its private institutions. This problem is based on neoliberal ideological assumptions that underpin the private healthcare system.[23] For example, almost four and half percent (4.4%) of GDP is spent on sixteen percent (16%) of the population using the private healthcare system. The private healthcare system accounts for almost 50% of the total national budget expenditure for healthcare to the benefit of a minority in the population. This reinforces inequalities within the healthcare system in that healthcare is provided for eight (8) million South Africans that have private medical insurance. On the other hand, the public sector provides free healthcare to the remaining forty-two (42) million people who make up eighty four percent (84%) of the population. This section of the population is without private medical insurance, but is dependent on the remaining four percent (4.1%) of GDP which makes up 47%

[23] The neoliberal assumption is that the private sector is in the healthcare business to generate profit whist the state is not offering healthcare services for any narrow profit interests. In the private sector healthcare is treated as a commodity that is traded in the free market system, whist for the state healthcare is decommercialized and is treated as a use-value.

of the national healthcare expenditure.[24] As a result, the public healthcare system is under strain and is collapsing. This is due to a two-tiered healthcare system that includes the private healthcare sector using the public healthcare budget to maintain its private operations.

The central research question that I seek to answer in the study is: to what extent do the neoliberal ideological systems that underpin the NHI policy and legislation ensure the realization of universal access to free quality healthcare for the poor and the working-class in South Africa? My sub-research question is: to what extent should the private healthcare system financially benefit from the NHI Fund? I provide a null hypothesis that the development of a policy to manage a two-tiered healthcare system may affect the NHI system negatively. If the NHI system is implemented in its current framework (in collaboration with the private healthcare system) then the private healthcare system may not make a positive contribution to the public healthcare system as assumed. The objective of free healthcare, and free hospitalisation for all, may be circumvented by a neoliberal interpretation of UHC. Such an interpretation incorporates the use of the private healthcare system in offering healthcare services. In my view, co-opting the private sector will lead to an unregulated expansion of a private healthcare system that will maintain rising market related costs in accordance to the market system.

The aims of this research project are: *(1)* to analyze the ideological systems that underpin the NHI system using a dialectical materialist approach as a philosophical method of analysis; and *(2)* to show that there are ideological contradictions in offering free, universal, quality, state healthcare services in South Africa using the private healthcare system for delivery. To achieve the abovementioned aims will require *(i)* identifying the ideological framework in which the NHI system is framed in its policy and legislative context; *(ii)* an analysis of the ideological systems, principles, concepts, and sub-concepts that underpin the NHI system; *(iii)* an analysis of the contradictions between: *(a)* private-ownership and state-ownership of the means of production within the healthcare sector as evidenced in Marxism; *(b)* determining the concept of free healthcare for all using a Marxist method; and *(c)* building a philosophical and an ideological case for a single healthcare system in South Africa.

The rationale and significance of the study is that the Department of Health (DoH) has issued

[24] This point is also noted in the *Industrial Policy Action Plan (IPAP) Economic sectors and employment cluster: 2014/15 – 2016/17* (Department of Trade and Industry), 93. See also Econex's 2013 study of South Africa's private healthcare sector. It reveals that it accounts for 50% of the total expenditure yet it only supports 16% of the population.

an NHI White Paper (2015) after the South African government issued the National Development Plan (NDP, 2012). South Africa's proposals for the NHI system represent a subtle but profound continuity with the current two-tiered system. The policy and legislative changes being made presently may set the foundations for expanding the current healthcare system with a few modifications. This research will make a political and philosophical contribution to the African National Congress (ANC), particularly to policy discussions in the ANC NGC including legislative discourse regarding the implementation of the NHI system in South Africa. The broader social impact is that the NHI system is being implemented as NHI policy discourse and legislative processes move towards the establishment of the NHI Fund. This study is significant in that it can be used by the South African government to influence the direction that the NHI Fund should take. The study may also be used for advisory purposes towards shaping the NHI Fund to be an appropriate financing model for offering free healthcare in South Africa. It can also act not only as a practical guide but also as an ideological guide towards the implementation of the NHI system in such a way that it benefits the public sector and the poor in general and the working-class in particular.

It is important to acknowledge some of the limitations of this study. For one, a Marxist approach to this research is a limitation. In the analysis, I use a historical and materialist method of analysis within the philosophical paradigm of dialectical materialism. My choice of theoretical framework and methodological approach is also a limitation. I could have used the human rights-based approach (HRBA) as a normative lens and a methodological framework for analysis but I do not choose it as a framework. I consider it, but do not adopt it. As I go on to show, the HRBA does not permit a thorough race and class analysis, which is crucial to understanding the healthcare context in South Africa. As such, race and class discourse and an inclusion of inequalities of location between (and within) race groups is within the scope of this study. Moreover, what is within the scope of this research project is an ideological analysis of the contradictions within the NHI policy and legislation. An analysis of the public and private healthcare systems in South Africa goes beyond the scope of this research project. Similarly, analysing the philosophical framework of the entire healthcare system in South Africa as a single totality lies outside of the scope of this research. Furthermore, resource constraints to visit all the NHI Clinics in South Africa constitutes some delimitation. Instead, I opted to analyse policy and legislation that was published by the South African government on the NHI system.

1.4 Overview of the chapters

The following chapters are envisaged for this study:

1.4.1 Chapter 1

The first chapter provides a very brief overview, sketching only some very broad parameters, of the NHI policy and legislation in South Africa. This overview remains limited in its scope and depth. In the chapter, I provide a background to the study and a statement of the research problem. I incorporate research questions, hypotheses including the aims and objectives of the study. I also provide a rationale for the study and offer some assumptions. I conclude the chapter by showing the limitations to the study and a breakdown of the chapter outline.

1.4.2 Chapter 2

Following the introductory comments in the previous chapter, Chapter 2 takes up the difficult task of providing methodological clarification. It documents the human rights philosophy and considers the main characteristics of a human rights-based approach (HRBA) as a methodological framework. The chapter also discusses dialectical materialism (Marxism) as a theoretical framework. It offers a detailed discussion of Marxism and provides an explanation of dialectical materialism. It shows how both the HRBA and Marxist frameworks work in practice. In the chapter, I identify, discuss, and compare Marxist and human rights principles that play a role in facilitating an understanding of the healthcare system and the implementation of the NHI system in South Africa. Ultimately, however, I provide some rationale for not adopting the HRBA, notwithstanding its analytical and explanatory power.

1.4.3 Chapter 3

This chapter gives background to the ideological origins of privatization of healthcare in South Africa. It shows that towards the democratic transition, the apartheid government privatized certain features of the public healthcare system. It introduced free market-based principles into the healthcare economy, effectively creating a two-tiered system. Hence, the idea of healthcare provision being the responsibility of both the public and private healthcare sector pre-dates 1994. The chapter affirms that in the 1990s a debate raged within the African National Congress (ANC) regarding the strategic objective of the ANC. It also shows in detail the key debates of the *two-stage theory.* The *two-stage theory* suggests that the National Democratic Revolution (NDR) has two stages – the first stage is national democracy and the second stage is socialism. The aim of this chapter is to demonstrate that there was an ideological tension that characterized the debate on the strategic objectives of the ANC and the question of "ownership" and/or

"control" of strategic sectors of the economy.

1.4.4 Chapter 4

This chapter traces the historical evolution of the NHI policy within the policy shifts in the African National Congress (ANC) in the period of the democratic transition. It affirms that there are two competing healthcare systems that survive the ANC policy shifts. It locates the discourse on the NHI system within the historical policy shifts in the ANC. It shows that two healthcare systems developed in opposition to one another, one private (to service the minority) and the other public (to service the majority). The chapter also shows that the concept of free healthcare for all in a unified healthcare system emerged in 1997. However, there were forces pushing the economy towards a more socialist system. Such forces were calling for an overhaul of the two-tiered system and for the NHI system to be phased in.

1.4.5 Chapter 5

Chapter 5 offers a discussion on the NHI policy and legislation in the context of the NHI Green Paper (2011), NHI White Paper (2015 – 2017), NHI Bill (2018) and the Medical Schemes Amendment Bill (2018). It shows that the NHI legislation establishes the NHI Fund as a financing and implementing mechanism of the NHI system. The aim of the chapter is to show the tensions in the NHI policy and legislation. The argument in the chapter is that the NHI policy and legislation should be focused on improving the conditions of the public healthcare sector. Otherwise, it is unlikely to contribute to the transformation of the public healthcare system. Moreover, healthcare should be offered for free by the state *only* and should be secured for all and offered to all equally and paid for by the state. However, privatization should not be permitted in the healthcare sector. The private healthcare system must be negated.

1.4.6 Chapter 6

Chapter 6 compares competing ideologies: neoliberalism as an ideological paradigm for privatisation and socialism as an ideological paradigm for nationalization. These ideological systems underpin the two sectors. The chapter shows that these ideological systems compete. It then draws conclusions that are relevant to the discourse on the NHI system. The chapter uses dialectical materialism as a methodological framework to analyze the two healthcare sectors as complex systems. Nevertheless, the focus remains on the philosophical analysis of the ideological systems that underpin the NHI policy and legislation.

1.4.7 Chapter 7

Chapter 7 explores primary healthcare re-engineering as an aspect of the NHI policy and legislation and integrates elements of financing arrangements in the national implementation of the NHI system. It offers a brief account of the strategy for primary healthcare reengineering including how the NHI will be funded. It also integrates relevant policy documents in this regard. An overview of primary healthcare reengineering and NHI financing in the public healthcare sector is provided. What is noted in the chapter is that a human resource development strategy for the public healthcare is integral to the sustainability of the NHI system.

1.5 Conclusion

This chapter offered an introduction to the study. Firstly, it provided a background and a statement of the research problem. It articulated the central research question and included a sub-research question. It also offered hypotheses and outlined the aims and the objectives of the study, its limitations and scope, and the assumptions that inform the study and its significance. Lastly, it provided a chapter overview. In the next chapter I take up the important work of clarifying the methodology.

Chapter 2

Theoretical framework and methods of analysis

2. Introduction

2.1 Possible frameworks for analyzing the NHI system

In this chapter, I aim to set out a theoretical framework in terms of which the research question/s may be clarified and the substantive issues may be examined. In other words, I explain the methodology to be used in evaluating and analysing the situation regarding the proposed National Health Insurance (NHI) system's linking of the private healthcare sector to public healthcare provision. So, *(a)* I explain the interaction/interrelation between the private and public system – the dialectical unfolding of the socio-political and economic situation; *(b)* I consider two possible methodologies which may be related to the ideologies that underlie private and public healthcare provision.

2.1.1 Two possible approaches (and rationale for considering these approaches)

2.1.2 Reason for giving priority to the second approach

Essentially, I compare a human rights-based approach (HRBA) and dialectical materialism (Marxism). The chapter has two main sections. In the first section, it gives a brief historical background to human rights (which may be linked to liberal ideology thereby diminishing sociality and responsibility); and considers the main components and principles of a HRBA as a methodological framework for examining the NHI system. I depend on Morten Broberga and Hans-Otto Sano to define the HRBA as a methodological framework.[1] Throughout, I identify and discuss human rights principles that play particularly important roles in the implementation of the HRBA (as it can be easily linked to healthcare issues). Furthermore, I indicate my reservation regarding the HRBA as a methodological option. I argue that reliance on the HRBA tends to underplay or overlook a critical analysis of the complex relationships between race and class, and the interconnections with capital and labour that underpin healthcare in the South African context. The race dimension complicates the matter enormously. In the second section, I discuss Marxist principles and then provide a comparison between Marxism and the HRBA.

[1] Morten Broberga and Hans-Otto Sano, 'Strengths and weaknesses in a human rights-based approach to international development – an analysis of a rights-based approach to development assistance based on practical experiences,' *The International Journal of Human Rights*, (Copenhagen: Routledge, 2018) 664.

I also add the dimension of dialectic (which is difficult to include) though I hold that Marxism does not deal with racism adequately.[2] I then show how both methodological approaches work in practice and also show that a methodology emerging from the analysis of Marxist principles is more suitable to the present study.

Section I

2.2 Brief historical background to human rights

It was in the 17th century that Hugo Grotius (1583-1645) in *De Jure Belli Ac Pacis* (*The rights of war and peace*; 1625) that the term 'rights' was first carefully articulated.[3] Human rights were rights that were thought to exist in nature. This view was also held by Thomas Aquinas. He acknowledged rights as a product of natural moral law.[4] According to Sweet, Grotius recognised that though rights were abstract they could not be separated from the concrete. [5] However, it became clear that a discourse of rights needed to consider both the social environment and the characteristics of human beings.[6] Moreover, Hobbes, and Locke (and their successors) influenced political philosophy by recognizing that the status of natural moral law is unclear.[7] For them, the natural law of self-preservation became equivalent to the individual's right to life. Their focus became individual rights or the preservation of the rights of the individual. Individuals, however, could not be separated from their social and political context. Therefore, Sweet maintains that, "The history of the 'discourse' of human rights is fairly well known. While the existence of 'natural rights' is implied in works of antiquity it is only in the Middle Ages that we begin to see an acknowledgement of rights as distinct from 'the right."[8]

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[2] Note Fanon on "Stretching" Marxism: "In the colonies the economic infrastructure is also a superstructure. The cause is effect: you are rich because you are white and you are white because you are rich. This is why Marxist analysis should always be slightly stretched when it comes to addressing the colonial issue (BMWS: 1967, p.40).

[3] See: Hugo Grotius, *The Rights of War and Peace*, Book I (Indiana: Liberty Fund, Inc., 2005), 79; and William Sweet (Ed.), in an introductory chapter entitled, 'Theories of rights and political and legal instruments,' *Philosophical Theory and Universal Declaration of Human Rights* (Ottawa: University of Ottawa Press, 2013), 3.

[4] See: *Summa Theologica*, p.1353. Read Thomas Aquinas' objections and answer to the question, "Whether the natural law is the same in all men?"

[5] Sweet, *Philosophical Theory and Universal Declaration of Human Rights*, 3.

[6] Peter C. Myers, *From Natural Rights to Human Rights—And Beyond, Special Report No.* 197 (Wisconsin: Heritage Foundation, December 20, 2017), 25.

[7] See: John Locke, *Two Treatises of Government* (Vol. v) (London: J. Evans and Co., 1823), 162; and Thomas Hobbes, *Leviathan* (London: Oxford University Press, 1651), 166.

[8] Sweet, *Philosophical Theory and Universal Declaration of Human Rights*, 1.

What is common in the foremost conception of human rights is the notion of liberty: a shield that safeguards the individual.[9] This is the core value of human rights – a Western liberal conception, a triumph of Hobbesian-Lockean individualism.[10] The purpose of such individualized human rights was to prevent undue interference from others. When seen from the foregoing perspective, human rights are properties of individuals which reflect the function or class position they have in various communities and in society. The driving force behind human rights is the determination of people demanding respect for human dignity.[11] Human rights are therefore understood as being inalienable rights to which a person is inherently entitled by virtue of being human.[12] They are an agreed set of values that exist to ensure human dignity and the fulfilment of basic human needs.[13] Central to the concerns of human rights are human life and dignity.[14]

The United Nations (UN) Charter (1945) defines human rights in a legally non-binding form. It proclaims that one of the purposes of the UN is to promote and encourage respect for human rights. This was given expression in the promulgation of the Universal Declaration of Human Rights (UDHR, 1948) by the United Nations General Assembly.[15] An impressive list of Articles on human rights that call for justice, equality, and respect for human dignity is enumerated in the UDHR.[16] Sweet suggests that apart from the rights to "life, liberty and security of a person" (Article 3); "freedom of conscience and thought and expression" (Article 19), and "freedom of peaceful assembly and association" (Article 20); in the "dignity and free development of [human] personality" entailed "[are] cultural and economic rights."[17] Such

[9] Individual liberty tolerates private capital accumulation and private property ownership, and even legitimates the exploitation of the poor and the working-class.

[10] Sweet, *Philosophical Theory and Universal Declaration of Human Rights*, 3.

[11] Sweet, *Philosophical Theory and Universal Declaration of Human Rights*, 1.

[12] Lidewij van der Ploeg and Frank Vanclay, 'A human rights-based approach to project induced displacement and resettlement,' in *Impact Assessment and Project Appraisal*, Vol. 35, No. 1, 34–52 (Groningen: Taylor and Francis, 2017), 35.

[13] Van der Ploeg and Vanclay, 'A human rights-based approach to project induced displacement and resettlement,' in *Impact Assessment and Project Appraisal*, 35.

[14] Franziska Walter, Manfred Nowak, Christine Sommer, Helmut Sax, Georg Huber-Grabenwarter, *Human rights manual: Guidelines for implementing a human rights-based approach in ADC*, (Vienna: Austrian Development Agency, 2010), 6.

[15] To keep a balance, note that UN Declaration is linked to many constitutions on race and gender. Also, collective rights respond to such issues.

[16] See the Universal Declaration of Human Rights (UDHR, 1948), as agreed and adopted by the United Nations (UN).

[17] Sweet, *Philosophical Theory and Universal Declaration of Human Rights*, 1. For an example of collective rights, in addition to the UN document, see: *(i)* the African Charter on Rights, and (b) many subsequent Conventions such as 'The Racial

rights are held to be universal and are ascribed to human persons.[18] Conceived more negatively (as rights from) such rights required intervention (not abstention) for the purposes of assuring equitable participation in the production and distribution of values. The UDHR (1948) set down two categories of rights – civil and political rights, and economic, social and cultural rights.[19] Civil rights entailed amongst others, rights to privacy, freedom of movement, opinion, conscience, association and assembly, and religious worship. On the other hand, political rights referred to the right to vote, equal access to government authorities, freedom of political parties, and the right of petition.

2.3 A human rights-based approach (HRBA)

2.3.1 Historical background

In this sub-section, I will explain the principles guiding human rights thinking, or the assumptions behind human rights – with reference to healthcare.

The processes of decolonization in Africa unfolded parallel to the growing global importance of human rights. Notably, decolonization was not to be the case in South Africa. But some organisations then chose to adopt a human rights-based approach (HRBA) as a basis for embracing new policies during the democratic transition.[20] Particularly in South Africa, development assistance became an important aspect, especially in the 1990s. Broberga and Sano point out that human rights gained prominence as an instrument of transformation and justice.[21] Over the last decade, the question of applying a so-called HRBA has frequently arisen.[22] According to the HRBA, the state (including non-state actors) have an obligation to

Discrimination Convention' and the 'International Convention on Apartheid.' Refer also to William F. Felice, *Taking suffering seriously: the importance of collective human rights* (New York: Sunny, 1996).

[18] I acknowledge that Eleanor Roosevelt from the beginning encouraged a non-individualistic interpretation of human rights. She held that the declaration could be applied in relation to communities as well as individuals. See Marry Ann Glendon, *A world made new: Eleanor Roosevelt and the declaration of human rights* (New York: Random House, 2001) Preface; Glendon also wrote: *Rights talk: the impoverishment of political discourse* (New York: Free Press, 1991) which shows the limits to American liberal interpretations of rights. Note also Felice (footnote 17).

[19] Moreover, rights discourse developed to first, second, and third generation rights. See John Warwick Montgomery, *Human rights and human dignity* (Edmonton: Canadian Institute for Law, Theology, and Public Policy Inc, 1993).

[20] Alice Donald, 'A guide to evaluating human rights-based interventions in health and social care,' *Human rights and social justice* (London: London Metropolitan University, 2012) 9.

[21] Broberga and Sano, 'Strengths and weaknesses in a human rights-based approach to international development – an analysis of a rights-based approach to development assistance based on practical experiences,' 666.

[22] Broberga and Sano, 'Strengths and weaknesses in a human rights-based approach to international development – an analysis of a rights-based approach to development assistance based on practical experiences,' 664.

prevent, and respond to, human rights violations, especially for the poor. Though different United Nations (UN) bodies apply diverging human HRBAs, according to United Nations International Children's Emergency Fund (UNICEF) a HRBA means that,

> [The] situation of poor people is viewed not only in terms of welfare outcomes but also in terms of *the obligation to prevent and respond to human rights violations*. For example, any action that excludes a specific group of children from school or discriminates against girls constitutes such a violation. The human rights approach aims to empower families and communities to secure assistance and advocates a fair and just distribution of income and assets.[23]

In view of the above description, the HRBA offers a methodological framework that will better enable organisations to understand society's expectations and deliver more sustainable services that are respectful of the inherent dignity of individuals.[24] The state and non-state actors have an "*obligation to prevent and respond to human rights violations.*" Therefore, any action "that excludes a specific group" or "discriminates" against any group in securing access to services that are considered to be a human right constitutes a human rights violation. In this sense, a HRBA considers the social, political, historical, and economic contexts that frame the ways in which particular services are produced, experienced, and understood. While a description of the HRBA is generally based on international human rights norms (taken from the UDHR and international human rights treaties), concepts from other discourses are also imported, such as ethics (notions of equity), good governance (rule of law), development and social justice (inclusion).[25]

Beracochea, Evans and Weinstein, point out that the HRBA is about giving people the ability to claim what is rightfully theirs as opposed to simply receiving aid, and that the challenge to a HRBA is to balance the rights of individuals (individual rights) with the rights of communities

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[23] Linda Jansen van Rensburg, 'A Human Rights-Based Approach to Poverty: The South African Experience,' in *The Many Dimensions of Poverty, edited by* N. Kakwani *et al.* (eds.), United Nations Development Programme (UNDP) 2007, 166. The United Nations Children's Fund (UNICEF) was originally known as the United Nations International Children's Emergency Fund. See also Broberga and Sano, 'Strengths and weaknesses in a human rights-based approach to international development – an analysis of a rights-based approach to development assistance based on practical experiences,' 666.

[24] Victorian equal opportunity and rights commission (VEOHRC), *From principle to practice: implementing the human rights-based approach in community organisations* (Melbourne: VEOHRC, 2008), 6.

[25] *UNAIDS Global Reference Group on HIV/AIDS and Human Rights*, 'Issue paper: What constitutes a rights-based approach? Definitions, methods, and practices,' 1.

(group rights).[26] Based on a call for the development of a common method in the HRBA, *The Human Rights-Based Approach Statement of Common Understanding* was developed under the auspices of the United Nations Development Programme (UNDP). Despite ideological controversies the United Nations (UN) succeeded in developing a set of norms for the protection of human rights, which was drafted through consensus and are a synthesis of three different 'generations' or 'dimensions' of human rights.[27] In the context of the healthcare system, according to Beracochea *et al.*, the *Common Understanding* states that human rights principles should guide all phases in the healthcare sector and that human rights principles may guide public healthcare systems more generally through the incorporation of a HRBA.[28]

To contextualize the basic human rights principles discussed in the *Common Understanding,* they emphasise the following elements – that health as a human right is: *(i)* universal and inalienable; *(ii)* indivisible; *(iii)* interdependent and interrelated; *(iv)* and that all people (individuals or groups) are equal as human beings and by virtue of the inherent dignity of each person all human beings are entitled to healthcare as a human right, without discrimination. A HRBA is based on the premise that discrimination and inequality are among the most important causes of poverty.[29] The principle of non-discrimination recognises that some people and groups in society, at different times and in different circumstances, face discrimination in the enjoyment of their human rights.[30] The commitment to non-discrimination and equal opportunities entails taking special account of discriminated and marginalised persons and groups who are thus hindered in exercising and enjoying their rights.[31] Targeted action is needed to address these inequities.

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[26] Elvira Beracochea, Dabney P. Evans and Corey Weinstein, in *Rights-based approaches to public health*, edited by Elvira Beracochea, Corey Weinstein and Dabney P. Evans (New York: Springer, 2011), 11.

[27] Walter, Nowak, Sommer, Sax, Huber-Grabenwarter, *Human rights manual: Guidelines for implementing a human rights-based approach in ADC*, 8. Walter, et.al, continues to state that, "A typical outcome of this synthesis is the International Charter of Human Rights, which consists of the Universal Declaration of Human Rights of 1948 and the 1966 International Covenants on Civil and Political Rights on the one hand and Economic, Social and Cultural Rights on the other. Both covenants include the collective right of self-determination of peoples in Article 1."

[28] Beracochea, Evans and Weinstein, *Rights-based approaches to public health*, 10.

[29] Broberga and Sano, 'Strengths and weaknesses in a human rights-based approach to international development – an analysis of a rights-based approach to development assistance based on practical experiences,' 668.

[30] Donald, 'A guide to evaluating human rights-based interventions in health and social care,' 6.

[31] Walter, Nowak, Sommer, Sax, Huber-Grabenwarter, *Human rights manual: Guidelines for implementing a human rights-based approach in ADC*, 18.

Underpinning the principle of non-discrimination is the idea that human rights are universal: everyone has rights regardless of their identity or background and rights are not privileges to be 'earned' or a matter of discretion.[32] For development cooperation purposes, according to Walter *et.al*, this means paying attention, for example, to which groups suffer most from poverty, discrimination and vulnerability and working towards identifying and removing all legal, economic, political, social and cultural barriers that impede the equal exercise of rights.[33]

However, where a HRBA is operationalized and applied the focus is likely to be less on service delivery and general capacity building. Instead, the focus is likely to be on enabling the *duty-bearer* – typically a developing state – to respond to claims from the ultimate recipients of the development assistance and to ensure that minimum core-rights regarding health, education, housing and/or social security are fulfilled.[34] This is a point that I will take up later when comparing the HRBA to Marxism. Human rights law has played an important role in the HRBA, yet there is no uniform approach.[35] Notably, Broberga and Sano point out that,

> [There] is no single [HRBA], but rather a number of variations thereof exist. Still, despite these variations between the different approaches they all place particular emphasis on human rights implementation through human rights principles of non-discrimination and participation. The fact that there is not merely 'one approach,' but rather that there are more variations, is important to keep in mind.[36]

The HRBA denotes a new approach with many variations, as the above quote suggests. As an approach, it views human rights as *(i)* a set of legal standards and obligations and *(ii)* a source of principles and practical methods which determine how those standards and obligations should be achieved.[37] However, Broberga and Sano show that a HRBA entails the promotion of legal rights and legal capacity building within the context of (international) development

[32] Donald, 'A guide to evaluating human rights-based interventions in health and social care,' 6.

[33] Walter, Nowak, Sommer, Sax, Huber-Grabenwarter, *Human rights manual: Guidelines for implementing a human rights-based approach in ADC*, 18.

[34] Broberga and Sano, 'Strengths and weaknesses in a human rights-based approach to international development – an analysis of a rights-based approach to development assistance based on practical experiences,' 668.

[35] *UNAIDS Global Reference Group on HIV/AIDS and Human Rights, 4th Meeting, 'Issue paper: What constitutes a rights-based approach? Definitions, methods, and practices,'* (*23-25 August 2004*), 1.

[36] Broberga and Sano, 'Strengths and weaknesses in a human rights-based approach to international development – an analysis of a rights-based approach to development assistance based on practical experiences,' 665.

[37] Donald, 'A guide to evaluating human rights-based interventions in health and social care,' 3.

activities.[38] Thus, from a HRBA perspective, human rights are both an end and a means. How HRBAs are implemented appears to have more to do with the mission and objectives of an agency or organization than the approach.[39] According to Broberga and Sano a HRBA is a way (or a 'method') of implementing human rights. Hence, there is no fixed template for how to embed human rights thinking and practice into an organisation or service. It is a creative rather than a prescriptive process. Thus, understanding the relationship an organisation has with human rights means taking a HRBA to operational practices. Therefore, a HRBA encourages a collective human rights approach within organisations to identify all stakeholders within its sphere of influence and to identify which of these stakeholders have human rights and corresponding duties; it considers the relevant stakeholders' capacity for participation; and assesses the extent to which the organisation's practice needs to improve in relation to key human rights principles.[40] To a certain extent the application of a HRBA has been adopted by domestic actors active in the field of development in the developing countries.[41] Agencies and organizations have often improvised in defining for themselves what constitutes a HRBA.[42] Moreover, a HRBA implies that people are active subjects with legal claims and that they need to participate in all spheres of society on an equal basis.

2.3.2 Principles of the HRBA

There are five key themes and/or normative principles which are fundamental elements of a HRBA. Three of these themes set the context. According to Love and Lynch, the three key themes are personalization, empowerment, and enablement.[43] It may be important to see how the basic principles seem to imply an ideology of individualism; even if it makes some attempt to accommodate collectivism. The normative principles are (1) Participation and inclusion (2) Accountability (of *duty-bearers* to *rights-holders*), (3) Non-discrimination and equality (including prioritisation of vulnerable groups), (4) Empowerment (of *rights holders*), and (5)

[38] Broberga and Sano, 'Strengths and weaknesses in a human rights-based approach to international development – an analysis of a rights-based approach to development assistance based on practical experiences,' 664.

[39] *UNAIDS Global Reference Group on HIV/AIDS and Human Rights*, 'Issue paper: What constitutes a rights-based approach? Definitions, methods, and practices,' 1.

[40] VEOHRC, *From principle to practice: implementing the human rights-based approach in community organisations*, 11.

[41] Broberga and Sano, 'Strengths and weaknesses in a human rights-based approach to international development – an analysis of a rights-based approach to development assistance based on practical experiences,' 665.

[42] *UNAIDS Global Reference Group on HIV/AIDS and Human Rights*, 'Issue paper: What constitutes a rights-based approach? Definitions, methods, and practices,' 1.

[43] John. G. Love and Rory Lynch, 'Enablement and positive ageing: a human rights-based approach to older people and changing demographics,' *The International Journal of Human Rights,* Vol.22, No.1, (London: Routledge, 2017), 94.

Legality and programming (application of a human rights framework) or linkages with human rights standards (progressive realisation of rights and non-retrogression).[44] Having identified stakeholders, their various rights and responsibilities, and opportunities to develop capacity, the final consideration informing what an organisation will do is to assess its priority setting and processes against these five key human rights principles.[45]

When such principles are violated, Beracochea *et al.*, maintain that aggrieved *rights holders* are entitled to institute proceedings for appropriate redress before a competent court or other adjudicator in accordance with the rules and procedures provided by law.[46] Therefore, there are compelling legal and practical reasons to support such an approach.[47] The HRBA involves a consideration of both *what* is to be done and *how* it is to be done. Deciding *what* is to be done will be based on a consideration of the human rights of the target community and their capacity, as well as their human rights obligations. With regards to implementation and operationalization, Broberga and Sano suggest that,

> Under a rights-based approach, donors support duty-bearer efforts to fulfil their human rights obligations. In other words, development assistance contributes to the realisation of the rights entitlements of the recipients. A rights-based approach also entails supporting the rights-holders in claiming their rights. Where a donor goes from a 'traditional' development assistance approach to a human rights-based approach this implies conceptually that the recipients are transformed from passive recipients of alms to active rights-holders.[48]

Broberga and Sano suggest that under a HRBA, donors support *duty-bearer* efforts to fulfil their human rights obligations. Once a donor organisation has established *what* it will do, it can then consider how it will implement its priorities in a way that promotes human rights.[49] Mainstreaming a HRBA in development cooperation programmes and projects ultimately aims at making interventions in a given context as effective and sustainable as possible, *i.e.* at

[44] Donald, 'A guide to evaluating human rights-based interventions in health and social care,' 5. The principle of *linkages* is taken from '*From principle to practice: implementing the human rights-based approach in community organisations*,' (p.11) published by the VEOHRC.

[45] VEOHRC, *From principle to practice: implementing the human rights-based approach in community organisations,* 12.

[46] Beracochea, Evans and Weinstein, *Rights-based approaches to public health*, 10.

[47] VEOHRC, *From principle to practice: implementing the human rights-based approach in community organisations,* 6.

[48] Broberga and Sano, 'Strengths and weaknesses in a human rights-based approach to international development – an analysis of a rights-based approach to development assistance based on practical experiences,' 667.

[49] VEOHRC, *From principle to practice: implementing the human rights-based approach in community organisations,* 11.

reaching the target groups and initiating and supporting changes.[50] According to Beracochea *et al.*, "Individuals and groups are often referred to as *rights-holders* because the rights discussed in the human rights paradigm are predominantly described in terms of the individual. These rights adhere to individuals because we are human and we are inherently born in dignity."[51] Broberga and Sano concur with Beracochea *et al.*, and further affirm that,

> Where private persons may appear to be the principal duty-bearers with regard to certain rights – such as the right to a healthy environment – a [HRBA] still requires that the rights-holder is capable of enforcing this right against the duty-bearer, and in practice this is likely to mean that the rights-holder must have access to public authorities such as courts, police, and political representatives at the local or national levels.[52]

The above quotation speaks to the characteristic aspect of operationalization and assessment that may result in an organisation re-shaping or re-prioritising what it will do.[53] Moreover, it only makes sense to talk of a 'right' if there is a corresponding obligation.[54] *Rights holders* are capable of enforcing their rights against the *duty bearers*. Hence, applying a HRBA demands more than adding certain people to the target groups it means adhering to human rights principles that underpin international human rights law.[55]

A key principle in the HRBA is that of participation. The principle of participation means that the poor are not just treated as *victims* but also as *actors*.[56] The poor have a right to participate in decisions that affect their lives. Moreover, a process of change is more likely to be effective if all the communities of interest concerned participate in it systematically – especially those whom it is meant to benefit.[57] The recognition of human rights in the community, with specific

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[50] Walter, Nowak, Sommer, Sax, Huber-Grabenwarter, *Human rights manual: Guidelines for implementing a human rights-based approach in ADC,* 22.

[51] Beracochea, Evans and Weinstein, *Rights-based approaches to public health*, 13.

[52] Broberga and Sano, 'Strengths and weaknesses in a human rights-based approach to international development – an analysis of a rights-based approach to development assistance based on practical experiences,' 668.

[53] VEOHRC, *From principle to practice: implementing the human rights-based approach in community organisations,* 11.

[54] Broberga and Sano, 'Strengths and weaknesses in a human rights-based approach to international development – an analysis of a rights-based approach to development assistance based on practical experiences,' 667.

[55] Federal ministry for economic cooperation and development, *A human rights-based approach to disability in development: Entry points for development organisations,* 5.

[56] Walter, Nowak, Sommer, Sax, Huber-Grabenwarter, *Human rights manual: Guidelines for implementing a human rights-based approach in ADC,* 18.

[57] Donald, 'A guide to evaluating human rights-based interventions in health and social care,' 5.

duties and responsibilities on the part of others as a corollary, transforms people from mere passive objects of a legal or social order to active protagonists, from subjects to citizens.[58] Thus, one of the fundamental dynamics of a HRBA is that every human being is recognised as a *rights-holder* (a party who has a right to health) and who should be enabled as a key actor in processes and decisions that affect them rather than being a passive recipient.[59] Beracochea *et al.*, suggest that, "Fundamentally, human rights describe the relationship between individuals (or groups) and the State. This relationship forms the core of most human rights doctrine because nation states have, in recent history, become the most powerful entities in the world."[60] State power at times undermines the principle of participation, especially in asymmetrical power relationships between individuals and the state.

The principle of participation also calls for active citizens in organising private and public life. Thus, it is inextricably linked to the implementation of a number of other human rights such as: freedom of assembly, freedom of association and freedom of expression without fear of repression which are essential for the development of participation.[61] This capacity for participation is a means to ensuring human rights protection as an end-in-itself.[62] The HRBA is evidence-based. It also depends on partnerships between state (public) and non-state actors (private) in the implementation of its programs, particularly in the public healthcare system. Beracochea *et al.*, affirm that,

> In a [Human Rights-Based] public health system, the government has to fulfil everyone's right to health through evidence-based and effective services at national, state, and local levels. A well-implemented rights-based program or service calls for ensuring that everyone's rights are considered and everyone's responsibilities are accounted for. Partnerships between local governments and civil society organisations and stronger advocacy for the rights of the poor and the sick are essential.[63]

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[58] Walter, Nowak, Sommer, Sax, Huber-Grabenwarter, *Human rights manual: Guidelines for implementing a human rights-based approach in ADC*, 6.

[59] VEOHRC, *From principle to practice: implementing the human rights-based approach in community organisations*, 12.

[60] Beracochea, Evans and Weinstein, 11.

[61] Walter, Nowak, Sommer, Sax, Huber-Grabenwarter, *Human rights manual: Guidelines for implementing a human rights-based approach in ADC*, 18.

[62] VEOHRC, *From principle to practice: implementing the human rights-based approach in community organisations*, 12.

[63] Beracochea, Evans and Weinstein, 11.

In this framework, the government is not the only healthcare services provider, other actors such as faith-based organisations (FBOs), non-government organisations (NGOs), and non-profit organisations (NPOs) participate in offering healthcare services. Essentially, public and private partnerships between the government and civil society organisations are imperative to the HRBA. In order to fulfil their obligations *duty-bearers* (who hold a duty mirroring rights) need the necessary resources and authority to perform their function, and data to plan and monitor the realisation of rights and accountability.[64] An essential prerequisite for accountability is the transparency of all government affairs, *i.e.* unhindered, free access to understandable information and efficient accountability mechanisms in and out of court.[65] This is connected to the principle of the rule of law that binds governance to the law. Once goals for respecting, protecting and fulfilling rights are set, clear mechanisms need to be created that allow people to hold to account those with responsibility for ensuring these goals are met.[66] This aspect speaks to advocacy and activism, which is a characteristic of the HRBA. Broberga and Sano maintain that the importance of activism and advocacy follows from the fact that the principles of participation and inclusion are central to implementing a HRBA.[67] The integration of human rights into the work of development cooperation also includes greater emphasis on the principle of accountability. Walter *et.al*, affirms that this sets out the rights of discriminated groups (and with that the target group) in relation to duty bearers, usually the government and its representatives, but also enterprises.[68]

Another key principle of the HRBA is that of empowerment. The principle of empowerment recognises that human rights are largely meaningless if rights-holders are not aware that they have them or lack the ability or means to claim them.[69] According to Broberga and Sano, the principle of empowerment implies that each individual and group acquires the ability to think and to act freely, to take decisions and to fulfil their own potential as an equal member of

[64] VEOHRC, *From principle to practice: implementing the human rights-based approach in community organisations,* 12.

[65] Walter, Nowak, Sommer, Sax, Huber-Grabenwarter, *Human rights manual: Guidelines for implementing a human rights-based approach in ADC,* 21.

[66] Donald, 'A guide to evaluating human rights-based interventions in health and social care,' 5.

[67] Broberga and Sano, 'Strengths and weaknesses in a human rights-based approach to international development – an analysis of a rights-based approach to development assistance based on practical experiences,' 668.

[68] Walter, Nowak, Sommer, Sax, Huber-Grabenwarter, *Human rights manual: Guidelines for implementing a human rights-based approach in ADC,* 20.

[69] Donald, 'A guide to evaluating human rights-based interventions in health and social care,'6.

society.[70] It is in this process of emancipation, of empowerment that the real revolutionary force of human rights lies, distinguishing it from other systems of values.[71] Furthermore, Walter *et.al,* maintain that,

> [Empowerment] is thus a process of enablement, in the course of which knowledge or specific skills are imparted, such as information on international human rights commitments of the respective government and on rights deriving from national law, helping to identify actual injustice. On the other hand, empowerment is also effected by the change in perspective of a human rights-based approach, which must ultimately lead to overcoming relations of dependency: through the focus on rights inherent to each person and the related accountability of the respective state (donor and partner countries).[72]

The application of human rights standards can be described as using a human rights 'lens' to view and reframe certain problems, experiences and relationships.[73] In doing this there are common procedures that involve legality and programming. Programing means a process by which organisations consciously and explicitly apply a human rights analysis, or filter, to a consideration of what they will do. [74] In this way, human rights become as much a part of an organisation's priority equation as other considerations.[75] Human rights programing involves steps in which organisations scan their operating environment to assess how human rights principles and standards intersect with, and should guide, their priorities.[76] A dual strategy is often adopted, and two prospective target groups are chosen for a legal programme, *i.e.* people as *rights-holders* (improving their access to the right to health) and people as *duty-bearers* obliged to ensure these rights (those bearing government responsibility).[77] Thus, Broberga and Sano maintain that a HRBA therefore presupposes that it is possible to invoke the right against

[70] Broberga and Sano, 'Strengths and weaknesses in a human rights-based approach to international development – an analysis of a rights-based approach to development assistance based on practical experiences,' 668.

[71] Walter, Nowak, Sommer, Sax, Huber-Grabenwarter, *Human rights manual: Guidelines for implementing a human rights-based approach in ADC,* 6.

[72] Walter, Nowak, Sommer, Sax, Huber-Grabenwarter, *Human rights manual: Guidelines for implementing a human rights-based approach in ADC,* 19.

[73] Donald, 'A guide to evaluating human rights-based interventions in health and social care,' 6.

[74] VEOHRC, *From principle to practice: implementing the human rights-based approach in community organisations,* 11.

[75] VEOHRC, *From principle to practice: implementing the human rights-based approach in community organisations,* 11.

[76] VEOHRC, *From principle to practice: implementing the human rights-based approach in community organisations,* 11.

[77] Walter, Nowak, Sommer, Sax, Huber-Grabenwarter, *Human rights manual: Guidelines for implementing a human rights-based approach in ADC,* 22.

a sufficiently well-functioning state.[78] A well-functioning state is a precondition for a well-functioning HRBA. According to Walter *et.al,* this starts with a broad analysis of the setting, the relevant actors and their scope of influence; added to this, is an analysis of the human rights framework (ratifications of human rights treaties, basic national, legal and political framework, *etc.*).[79] A comparison is made between this normative framework and the specific responsibilities in a particular context, *i.e.* who should be entrusted with which task.[80] Based on this, approaches are developed to bridge the gap between mandate and execution, including formulating strategies for cooperation among certain actors to help those affected to be better able to claim their rights and the duty-bearers to perform their tasks more effectively.[81]

2.4 NHI system within the framework of a HRBA

2.4.1 Application of HRBA to the NHI system

Now, I consider how the HRBA may be applied to the NHI system:

A HRBA provides a common language through which policy and legislation can be objectively measured against universal benchmarks and minimum standards.[82] In practice, Broberga and Sano assert that the application of a HRBA involves governments (and their agencies), intergovernmental organisations and international as well as local non-governmental organisations (NGOs).[83] This allows an understanding of challenges and dilemmas from the perspective of all relevant stakeholders, and a better management of social risk.[84] In order to examine the NHI system within the methodological framework of the HRBA, it is important to understand the South African model of the NHI system as a financing mechanism that is aimed at ensuring free quality healthcare provision for all citizens and non-citizens in South Africa – regardless of their employment status or their ability to make a direct financial contribution to the NHI Fund. The goal of the NHI system is the creation of an equitable *unified*

[78] Broberga and Sano, 'Strengths and weaknesses in a human rights-based approach to international development – an analysis of a rights-based approach to development assistance based on practical experiences,' 667.

[79] Walter, Nowak, Sommer, Sax, Huber-Grabenwarter, *Human rights manual: Guidelines for implementing a human rights-based approach in ADC,* 22.

[80] Walter, Nowak, Sommer, Sax, Huber-Grabenwarter, *Human rights manual: Guidelines for implementing a human rights-based approach in ADC,* 22.

[81] Walter, Nowak, Sommer, Sax, Huber-Grabenwarter, *Human rights manual: Guidelines for implementing a human rights-based approach in ADC,* 22.

[82] VEOHRC, *From principle to practice: implementing the human rights-based approach in community organisations,* 6.

[83] Broberga and Sano, 'Strengths and weaknesses in a human rights-based approach to international development – an analysis of a rights-based approach to development assistance based on practical experiences,' 665.

[84] VEOHRC, *From principle to practice: implementing the human rights-based approach in community organisations,* 11.

healthcare system given South Africa's currently fragmented and two-tiered healthcare system. Given the design of the NHI system as a strategic purchasing system that aims to purchase healthcare in the private healthcare system, such a goal may be undermined in that the NHI system may end up serving private healthcare sector interests *only*. Nevertheless, the implementation of the NHI system in South Africa remains a government priority. However, I will eventually suggest/argue that the NHI system may not be equitable – it may end up serving private healthcare interests only. I will also argue that the HRBA is not able to adequately identify the problems. First, let me outline the NHI system and relate it to the HRBA framework.

It appears that the NHI system is based on the principles of human rights to health (as adopted by the United Nations). Such principles include social solidarity and Universal Health Coverage (UHC) endorsed by the World Health Organisation (WHO). UHC has to do with ensuring that all people have access to quality healthcare services while also ensuring that people do not suffer financial difficulties when paying for such services. Yet, South Africa's public healthcare system is free at the point of care for the entire population especially the poor, thereby ensuring that people do not suffer financial hardship when accessing public healthcare services. However, the private healthcare system in South Africa is not free. By contrast, the poor and the working-class suffer serious financial challenges when paying for its privately offered and expensive services. It is in this context, that the NHI system as currently designed, when purchasing healthcare services in the private healthcare sector, serves private sector profit interests.

The private healthcare system in South Africa is not only expensive but it is inaccessible to the poor and the working-class. Currently, access to the private healthcare system is mediated by private medical insurance, which to a certain extent is afforded by the middle and the upper class of South African society. Structurally, the NHI system as a financing mechanism is designed to provide access to the private healthcare system for all in the population – with the NHI Fund acting as a state medical insurance fund – with patients using the NHI Card to access the healthcare system. The private healthcare sector is considered to be a non-state actor in competition with the state in the healthcare system. But the public healthcare system is in a poor condition, whilst the private healthcare system offers perceived high-quality care. However, in both systems health is considered to be a basic human right. Hence, a HRBA becomes a key methodological framework advanced by certain class forces in certain sections and social strata in South African society. Such class forces are linked to racialized private

healthcare sector profit interests in order to implement a model of the NHI system in South Africa that aids the expansion of the conglomerate private healthcare sector as a non-state actor in a two-tiered healthcare economic system. With this context, it is important to examine the NHI system within the framework of a HRBA.

The HRBA as a framework has important elements that are identified as the main principles that underpin human rights-based interventions within a private organisational dimension.[85] As such, a private organisational dimension means the type of activity that is made visible in private structures and private processes to make certain human rights principles seem meaningful. In such a dimension, the NHI system is seen to be a human rights-based intervention. Such a system will put certain structures and processes in place, but taking into consideration that there is no single blueprint for implementing human rights principles in a private organisational dimension.[86] The specific application of the HRBA in the private healthcare system depends on the different stakeholders: *rights-holders*, *duty-bearers*, and supporting actors (such as NGOs and/or donors).[87] Within this context, the state as an *actor* is considered to be a *duty bearer*, or at least one of the duty bearers (others being non-state actors) with the responsibility to offer healthcare services. Beracochea *et al.*, point out that, "States are known as *duty bearers* because they assume responsibility to promote and protect human rights."[88] The state and non-state actors are both considered to be important duty bearers with a corresponding obligation to provide healthcare services to *rights holders*.

The concepts of a *duty bearer* and *rights holder* are important concepts of the HRBA. However, the state is abstract. Hence, public healthcare professionals, working directly for the state or government agencies are themselves concrete state actors. The public healthcare facilities and the public healthcare workers as state actors are also *duty bearers* (*i.e.* nurses, doctors, optometrists, dentists, audiologists, *etc*.) the patients are *rights holders*. If such professionals, as patient-care givers, work for multinational corporations in the conglomerate private healthcare sector (for example, in private clinics and private hospitals) or nongovernmental organisations, then they are considered non-state actors. In their capacity as healthcare professionals, and as *duty bearers*, they assume certain rights and corresponding

[85] Donald, 'A guide to evaluating human rights-based interventions in health and social care,' 5.

[86] Donald, 'A guide to evaluating human rights-based interventions in health and social care,' 7.

[87] Broberga and Sano, 'Strengths and weaknesses in a human rights-based approach to international development – an analysis of a rights-based approach to development assistance based on practical experiences,' 665.

[88] Beracochea, Evans and Weinstein, 14.

responsibilities. The private organisations that they work for are also referred to as *duty bearers*. But in such institutions, at an individual level, professional healthcare staff have been found to resist taking a HRBA. Love and Lynch suggest that,

> [There is a misconception that] such a way of working [is] unduly bureaucratic and intrusive. Invoking political tropes promoted by a sometimes hostile media, human rights become aligned with notions of 'political correctness,' the 'latest fashion' and a 'compensation culture,' notions that discourage staff from seeing the positive and aspirational dimension of human rights that can challenge the status quo and enable [patients] to attain optimal levels of well-being, dignity and fulfilment. As such, an estimated half a million [patients] may be suffering from abuse at any given time, a third of which is perpetrated by paid workers.[89]

The HRBA is bureaucratic, hence it can be seen as intrusive. In view of the above quotation, the HRBA is "aligned with notions of 'political correctness.'" Broberga and Sano suggest that there is no unambiguous and generally accepted understanding of how the HRBA should be operationalised, but there are common characteristics.[90] In the context of NHI policy and legislation, the state acts to create a single, publicly-owned, and state-administered strategic purchaser that will actively purchase healthcare services to be delivered on behalf of the entire population from accredited public and private healthcare service providers. A HRBA to service delivery and policy development involves a consideration of both *what* is to be done based on the principles of human rights and the corresponding duties one may have, and *how* work is going to be done in ways that promote human rights.[91] Within such a framework, the Office of Health Standards Compliance (OHSC) will oversee "*what is to be done*" by providing certification for "*how work is going to be done*" by both public and private healthcare providers as state and non-state actors. In this regard, there are attempts to come to a consensus on the meaning of a HRBA within the context of healthcare.[92]

I have identified and stated core concepts thus far (such as *duty bearers* and *rights holders*) and principles and objectives (such as responsibility to protect rights); though *rights holders* can

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[89] John. G. Love and Rory Lynch, 'Enablement and positive ageing: a human rights-based approach to older people and changing demographics,' *The International Journal of Human Rights*, Vol.22, No.1, (London: Routledge, 2017), 94.

[90] Broberga and Sano, 'Strengths and weaknesses in a human rights-based approach to international development – an analysis of a rights-based approach to development assistance based on practical experiences,' 665.

[91] VEOHRC, *From principle to practice: implementing the human rights-based approach in community organisations*, 6.

[92] Based on the empirical policy statements of leading actors (UN agencies, governments and international NGOs).

also be *duty bearers* when it comes to ensuring healthcare. For example, according to the HRBA, communities or groups, as with individuals, have the right to health, but also the duty to participate in healthcare delivery. However, in my assessment this view is not true when, for instance, the *rights holder* is a child. The child receiving a vaccine for instance, cannot be a *duty bearer*. Beracochea *et al.*, explains that,

> The final players within the field of human rights are non-State actors. Non-State actors may include any private individual or groups such as transnational or multinational corporations (referred to as TNCs and MNCs, respectively) as well nongovernmental organisations (NGOs) and civil society organisations (CSOs). Mediators between the two, particularly when the rights-holder cannot advocate for his or her own rights, are sometimes referred to as *rights claimers.*[93]

In view of the above quotation, another concept in the HRBA is that of *rights claimers.* For example, a parent may claim the right of a child to health, or a private organisation may claim the right of a victim of domestic violence to receive counselling or victims of sexual violation to receive antiretroviral treatment. Within the NHI system, such individuals will be protected from out-of-pocket expenses and the financial catastrophe that may be healthcare related. In this regard, there is a prevailing consensus that a HRBA may be used when considering the private healthcare system particularly as a non-state actor.[94] Strategic purchasing will occur in the private healthcare sector and will require private information systems to register and monitor utilisation. State procurement systems to ensure access into the private healthcare sector, it is assumed, will improve access to healthcare for all. In addition, Walter *et.al* further points out that,

> Of crucial importance therefore is that all [rights holders], particularly the most severely discriminated and disadvantaged persons and groups, are informed about their rights and can claim these from the relevant [duty bearers]. Similarly, the [duty- bearers] must evaluate their capacities for implementing the respective duties and support the relevant institutions to be able to meet their obligations.[95]

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[93] Beracochea, Evans and Weinstein, 11.

[94] *UNAIDS Global Reference Group on HIV/AIDS and Human Rights*, 'Issue paper: What constitutes a rights-based approach? Definitions, methods, and practices,' 1.

[95] Walter, Nowak, Sommer, Sax, Huber-Grabenwarter, *Human rights manual: Guidelines for implementing a human rights-based approach in ADC*, 21.

Rights holders, particularly the poor who are the most severely discriminated and disadvantaged in society, can claim access to healthcare as a right from the private healthcare system as *duty bearers* who are also *non-state actors*. The state as an *actor* and as a *duty bearer* must evaluate its capacity and respective duty for implementing the NHI system and for providing support to the relevant public and private healthcare institutions to be able to meet their obligations. To access their rights, *rights holders* require the capacity to access information, organise, advocate for policy and legislative change to obtain redress.[96] The NHI system (emerging as a result of a healthcare policy change) seeks to redress healthcare inequalities and to support the provision of private and public healthcare services for *right holders* particularly those from the most disadvantaged and marginalized members of South African society. In this sense, the HRBA provides a methodological framework to achieve this.

Whilst the HRBA has a normative basis in human rights, Broberga and Sano maintain that the starting point must be linked with the operational implementation of the rights *i.e.* the application of the rights in practice.[97] This is especially relevant for the state seeing that as a *duty bearer* it has an obligation to protect the human rights of *right holders*. Hence, within the HRBA, obligations are discussed using terms such as promote, protect, fulfil, and respect. Beracochea *et al.*, affirm that, "The obligation to *respect* is a pledge by the State to refrain from directly violating the right to health. The obligation to *protect* obliges the State to prevent other actors from violating the right to health. Finally, the obligation requires positive action on the part of the State towards the *fulfilment* of the right."[98] As a result, the NHI system has an obligation to extend coverage to the entire population; improve both the quality and quantity of healthcare services and products that the South African population will receive; as well as provide protection against financial risk protection to individuals and households; and reduce direct cost exposure when they access private healthcare services.

Within such a system, the provision of healthcare services will be through an integrated system that will involve private sector contracting. This will involve compliance legal norms and standards. Beracochea *et al.*, suggest that "states and other duty bearers are answerable for the observance of human rights. In this regard, they have to comply with the legal norms and

[96] VEOHRC, *From principle to practice: implementing the human rights-based approach in community organisations,* 12.

[97] Broberga and Sano, 'Strengths and weaknesses in a human rights-based approach to international development – an analysis of a rights-based approach to development assistance based on practical experiences,' 665.

[98] Beracochea, Evans and Weinstein, 14.

standards enshrined in human rights instruments."[99] However, with such an approach were non-state actors are also considered to be *duty bearers* with an obligation to "protect human rights," obligations are not clearly defined, specifically under the auspices of the current regime of human rights law. Moreover, as *duty bearers*, non-state actors are expected in the NHI system to participate in the transformation of the healthcare financing system and how healthcare services are to be funded; how this will occur is unclear. What seems clear is that the NHI system shall not discriminate against the private healthcare sector, instead there shall be cooperation between the two *actors* as *duty bearers* in offering healthcare services to *rights holders*. This is seen to be ethical and moral. Hence, there are ethical and moral arguments in favour of a HRBA for fostering cooperation between the two healthcare systems. As a result, the private healthcare sector shall be contracted by the state, thereby included to participate in the NHI system, and held accountable by the state.

What emerges is that the HRBA has elements of substance and process.[100] Throughout this process, fundamental human rights principles should be applied.[101] Broberga and Sano affirm that by linking the normative basis to its concrete implementation, the HRBA and in particular the principles of accountability and the rule of law, participation and inclusion, and equality and non-discrimination has created a methodological framework.[102] The assumption regarding the NHI system is that patients shall receive free quality healthcare and be treated equally at the point of care, in both healthcare systems. In view of this, contracting the private healthcare sector seems moral. Cooperation between the state and non-state actors appears to be ethical. Cooperation between the private and public healthcare systems within a two-tiered healthcare system seems to addresses the multiple barriers to the inclusion of certain people or groups.[103] Such cooperation between the state and contracted non-state actors, according to the HRBA, also contributes to the capacity development of *duty-bearers*, (*i.e.* states and their institutions acting with delegated authority) to meet their obligations, and of *rights-holders*, to claim their

[99] Beracochea, Evans and Weinstein, 10.

[100] *UNAIDS Global Reference Group on HIV/AIDS and Human Rights*, 'Issue paper: What constitutes a rights-based approach? Definitions, methods, and practices,' 2.

[101] Federal ministry for economic cooperation and development, *A human rights-based approach to disability in development: Entry points for development organisations*, 5.

[102] Broberga and Sano, 'Strengths and weaknesses in a human rights-based approach to international development – an analysis of a rights-based approach to development assistance based on practical experiences,' 667.

[103] Federal ministry for economic cooperation and development, *A human rights-based approach to disability in development: Entry points for development organisations*, (Germany: Deutsche Gessellschaft für Internationale Zussammenarbeit, 2011), 5.

rights.[104] Effectively, when applying the HRBA as a methodological framework, the two-tiered healthcare system is kept intact.

2.5 Weaknesses in the HRBA as a method for evaluating the NHI proposal

The HRBA does not take into consideration elements such as race and class, labour and capital, and the exploitation of the working-class and the poor masses, which are critical aspects of the South African political economy. In this sub-section, I argue that reliance on the HRBA leads to excluding from critical analysis the complex relationships between race and class, and the interconnections with capital and labour that underpin the healthcare system in the South African context.[105]

The healthcare system in South Africa is a discriminatory and an unequal system. It maintains a two-tiered healthcare system with both public and private features amidst a political atmosphere of reformism, austerity measures, privatisation and marketisation of healthcare. This system also exists within a political economy that is characterised by racialized inequalities. Such inequalities are shaped by a legacy of structural racial discrimination, and generalized abject poverty for the poor majority of the South African population. A HRBA is based on the premise that discrimination and inequality are among the most important causes of poverty. Therefore, according to the HRBA, targeted action is needed to address such discrimination and inequality. Hence, the South African model of the NHI system is designed in such a way that the NHI Fund will act as a strategic purchaser in the *two-tiered* healthcare system without discrimination, thereby purchasing healthcare in both the private and public healthcare sectors to address poverty and inequality within the system. Herein lies its weakness.

Notably, by private sector, in the HRBA framework, is meant other actors such as FBOs, NGOs, and NPOs participating in offering healthcare services. Both the private and public system are identified as equal stakeholders. Even though it is clear that such private non-state actors are not equal to the state in terms of their capacity to deliver healthcare services

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[104] Federal ministry for economic cooperation and development, *A human rights-based approach to disability in development: Entry points for development organisations* 4.

[105] According to Pogrund, "in race classification, most people had by this stage been assigned to their racial category. But hundreds of objections were still being considered by the special race classification appeal board. During the year [1949], 69 coloureds were reclassified as whites, three whites became coloureds, and 41 blacks were transformed into coloureds by the stroke of an official pen." See: Pogrund, *How can man die better: The life of Robert Sobukwe*, 285. Mandela recalled that, "the Population and Registration Act labelled all South Africans by race, making colour the most single most arbiter of an individual." See: Mandela, *Long walk to freedom: The autobiography of Nelson Mandela*, 130.

nationally. Essentially, the HRBA permits partnerships and cooperation between the government and the private sector. This is aligned to the key theme of "inclusion." As are result, the NHI system, framed this way, creates a process of enablement (empowerment) for the majority in the population (characterized as poor and working-class) to access the private healthcare system *en masse*. The weakness of the HRBA in this context is that it does not challenge the inclusion of the private healthcare system (with non-state actors) by the state in offering public healthcare services to the entire population. It does not provide a framework to contest this idea. It reinforces it.

The human rights-based idea is that of a commitment to non-discrimination against the private healthcare system and providing equal opportunities for access in both the private and public healthcare systems when considering purchasing healthcare. This entails taking account of the discriminated groups and the marginalised in society who are hindered (or prevented) from enjoying access to the private healthcare system. Therefore, the HRBA appears to empower marginalised *rights-holders* who lack the ability to claim healthcare in the private healthcare sector, yet in reality it facilitates narrow neoliberal and private sector profit interests. In this context, the concept of offering free quality healthcare for all in South Africa using healthcare institutions in the public sector *only* is undermined, though the necessity for the improvement of public healthcare services is not denied.

The principle of non-discrimination also recognises that some people and groups in society face discrimination and are unable to enjoy the right to healthcare. In the context of the HRBA, discrimination against accessing the private healthcare system is seen as, or interpreted to be, a human rights violation. Hence, according to the HRBA, the state as an actor must include non-state actors as *duty bearers* that have an obligation to prevent or respond to human rights violations, especially for the marginalised as *rights holders*. Underpinning this principle of non-discrimination is the idea that human rights are universal – that everyone has human rights regardless of their racial identity or economic background – and that rights are not privileges or a matter of discretion. However, South Africa remains a highly racialized capitalist country with a structurally unequal society and systems. Therefore, it is not possible to implement a HRBA in South Africa without constant references to "race," "racial groups," "racial categories," "racial inequality" or "racial class" – that is what colonialism and apartheid in South Africa had been about, and to avoid such references would be both confusing and require

a distortion of reality.[106] The reality in the conglomerate private healthcare system particularly in South Africa is that it serves mainly white capitalist profit interests, where quality healthcare becomes an expensive privilege for a minority group and a middle class section of society that can afford private healthcare. Given this context, the HRBA to the NHI system in South Africa is being used as a methodological justification to further shift state funds from the NHI Fund (as a strategic national budget for national public healthcare) into private businesses. Particularly, funds must shift from the state to private businesses operating within the conglomerate private healthcare system that is mainly white-owned. Yet, private healthcare systems are known to have been unable to successfully deliver free public healthcare services to any given national population, let alone the poor.

Though a HRBA as a methodological framework offers a human rights lens to view and frame the NHI system and its sub-systems as operationalized in the two-tiered healthcare system, such a healthcare system in South Africa remains a reflection of its colonial and apartheid history. The two healthcare systems (private and public) and their mode of production are embedded within a racially exploitative political economic system. Such a political economy reproduces apartheid relations of production. The concept of "race" in South Africa is interiorized into "class." Therefore, such a racialization of class translates into racialized inequalities (racialized inequalities of income, location, possessions, gender, education, employment, housing, healthcare, *etc.* especially between and within race groups). How then do human rights principles guide healthcare systems through the incorporation of a HRBA in such an economic system? The strategic goal of the NHI system is not only to offer free quality healthcare to all in South Africa, but to do this through a *unified* healthcare system. Framed within the HRBA, *unified* means cooperation between the two systems. A major weakness of the HRBA is that it does not offer a methodological framework for the negation of the private healthcare sector in offering healthcare services to the majority in the population. Within the framework of the HRBA, the term *unified* means a perpetuation of a public healthcare system where the private healthcare system remains intact but appears to be negated (whilst in reality it would not be negated). Instead, there would be a continuation and a perpetuation of the current *status quo*, wherein the introduction of the NHI Fund as a new variable into the current

[106] Benjamin Pogrund, *How can man die better: The life of Robert Sobukwe*, (Cape Town: Jonathan Ball Publishers, 2009), 1.

system would result in the phenomenal growth and profit expansion of the private healthcare system. Therefore, the HRBA is not suitable for me to use in this study.

Another weakness of the HRBA is that it permits a non-materialist understanding of the term *unified* in a non-dialectical and ahistorical sense. It does not take into consideration that non-state actors [such as for example the Life, Mediclinic, and Netcare Group of hospitals as *duty bearers* in the South African private healthcare system, that have an obligation to prevent and respond to human rights violations], are located (owned and controlled by whites) operating in former white areas (including former *Indians only* areas and former *Coloureds only* areas). Such an unequal structural social location and a racialized form of ownership and control of the private means of healthcare production reproduces a racialized inequality of location and apartheid relations of production within the current healthcare economic system. Therefore, the term *unified* in the policy and legislative documents may not necessarily mean one equal healthcare system but one strategic purchaser, and both systems (private and public) offering healthcare at the point of service, and retaining user fees for treatment and drugs, though managing NHI tariffs.

Additionally, the HRBA does not consider the fact that privatisation of healthcare in South Africa has racist ideological origins, and that financial exclusion of the majority of the population from accessing quality healthcare facilities was initially based purely on a racial ideological basis. The policy and legislative discourse of access to universal healthcare as a human right in South Africa occurs within a context were whites still live in "white areas" (or former *whites only areas*). Though there has been extensive racial integration in the former *Whites only* areas, there are better healthcare systems and healthcare infrastructure in such areas than in current "black areas" – where Africans, Coloureds and Indians live in their majority. In the black locations, there are some state-owned public clinics that offer primary healthcare, but these are not the same as those located in white communities. Moreover, both public clinics and hospitals that offer free healthcare are in an appalling condition, by comparison to private clinics and hospitals where healthcare is provided at a premium rate. Whites as a minority group, particularly in South Africa, have secured for themselves the best residential locations and the best that private healthcare systems have to offer. There remains a racial and class solidarity amongst them.[107] The majority of black people live in the townships and, to a greater

[107] Race was used as a social construct were people believed that there was a hierarchy of races; and that the lighter one is, the more intelligent they were (and the bigger the head, the smarter the person). There is no scientific validity for these

degree, villages in the rural areas – particularly for African people. In such villages (former Bantustans), that still remain cheap labour reserves, private hospital groups that provide healthcare services to the rural poor are non-existent. Therefore, a critical analysis of the complex relationships between race and class, capital and labour, in South Africa cannot be excluded in this study.[108] Race as a social category in South Africa was (and to some extent still is) underpinned essentially by the use of the concept of race to establish a hierarchy of asymmetrical power relationships by assigning not only value but social location and class location to categories of people defined as inferior or superior.[109]

To conclude this section: capitalist forces within the private healthcare sector will appear to resist the NHI policy and legislative position, posing a false offensive posture against the proposed NHI system, whilst simultaneously embracing and supporting the concept of UHC. In this context, and in accordance with the HRBA, quality healthcare cannot be universally accessible for free but only accessible at a cost that individuals can afford. Universalism in this context is the inclusion of the entire population in the private healthcare system on the basis of the ability to pay for healthcare (or be paid for by the state).[110] In this framework, the HRBA will lead to the use of user fees and charges in the healthcare system which everywhere have the effect of excluding the poor.[111] This poses a challenge to the dominant ideological paradigm of the HRBA. Where a HRBA is operationalized (and applied) the focus is less on service delivery, general capacity building, or improvement of material conditions. Instead, the focus is on enabling the *duty-bearer* (state and non-state) to respond to claims from the *rights holders* (ultimate recipients of assistance in society) and to ensure that minimum core-rights regarding healthcare are fulfilled.[112]

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theories. Racial theory had enormous consequences in apartheid South Africa. Most hospitals and clinics were taken over by national, provincial and local government departments of health under apartheid.

[108] Africans in general and blacks in particular, in South Africa were systematically denied civil and political rights including economic, social, and cultural rights. Instead they were systematically oppressed as a race group. They had no rights to privacy, neither had they freedom of movement or opinion or conscience or association and assembly. Black people were legally denied political rights and they did not have the right to vote, nor equal access to government authorities. This affected their mental and physical health.

[109] Mamphela Ramphele, *Laying ghosts to rest: Dilemmas of the transformation in South Africa* (Cape Town: Tafelberg, 2008), 73.

[110] John Lister, *Health policy reform: Global health versus private profit* (Oxford: Libri Publishing, 2013), 3.

[111] Lister, *Health policy reform: Global health versus private profit,* 3.

[112] Broberga and Sano, 'Strengths and weaknesses in a human rights-based approach to international development – an analysis of a rights-based approach to development assistance based on practical experiences,' 668.

Section II

In the following section, I discuss Marxist principles and then provide a comparison between a human rights-based approach (HRBA) and dialectical materialism (Marxism). I demonstrate how both methodological approaches work in practice and establish that a methodology emerging from the analysis of Marxist principles is more suitable to the present study.

2.6 Rationale for Marxism

My motivation for considering Marxism in this study is because of its *defacto* influence on the ANC/SACP. But more deeply, what attracts me to Marxism is its apparent concern with concrete oppression, and its concern for the oppressed. I am aware of the development of Marxism *(i)* the distinction between scientific Marxism (dialectical materialism) and critical Marxism (dialectical Marxism) generally; *(ii)* the unfolding of Marxism from Marx to Lukács and Gramsci to Merleau-Ponty and Leszek Kolawoski – a more 'humanist' Marxism.[113] Finally, a broader consideration of Marxism enables an appreciation of 'dialectical theory' as an 'epistemology' that explains how representing the world and changing it are interrelated.

2.6.1 Marxism: a theoretical framework

I will argue for Marxism as offering a more suitable methodology – a more detailed and explanatory account that is more effective in addressing issues of equity and justice. It is important to give a brief historical background:

When describing the dialectical method, Marx and Engels usually refer to Hegel as the philosopher who formulated the main features of the dialectic. Dialectics remains the art of arriving at the truth by disclosing the contradictions in the argument of an opponent and overcoming these contradictions. This process of change in which new ideas do not so much defeat the old as resolve conflicts or contradictions within them, Hegel called the dialectic.[114] Hegel was an idealist. However, this does not mean that the dialectic of Marx and Engels is identical with the dialectic of Hegel. Marx said that,

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[113] Note, both are found in Marx himself. However, dialectical materialism continues to inform the ideology of the South African Communist Party (SACP) and the Congress of South African Trade Unions (Cosatu). But critical Marxism is found in more reflective Marxists (and continues in the Frankfurt school). See Scott Warren, *The emergence of dialectical theory: philosophy and political inquiry* (Chicago: University of Chicago Press, 1984), offers a neat overview. Warren gives a genealogy of dialectical theory.

[114] Ben Fine and Saad-Filho, *Marx's Capital* (6th edition) (London: Pluto Press, 2014), 2.

> My [dialectical] method is not only different from the Hegelian [dialectical method], but is its direct opposite. To Hegel..., the process of thinking which, under the name of 'the Idea,' he even transforms into an independent subject, is the *demiurgos* [creator] of the real world, and the real world is only the external, phenomenal form of 'the Idea.' With me, on the contrary, the ideal is nothing else than the material world reflected by the human mind and translated into forms of thought.[115]

Lenin asserts that, Marx and Engels regarded Hegelian dialectics, the theory of evolution most comprehensive, rich in content and profound, "all other formulations of the principle of development, of evolution, they considered to be one-sided, poor in content, distorting and mutilating the actual course of development of nature and society."[116] Engels says that,

> Marx and I were almost the only persons who rescued conscious dialectics [from the swamp of idealism, including Hegelianism] by transforming it into the materialist conception of nature…Nature is the test of dialectics…in the last analysis, nature proceeds dialectically and not metaphysically.[117]

Marx maintains that, "It is not the consciousness of men that determines their being, but, on the contrary, their social being that determines their consciousness."[118] Lenin suggests that materialism explains consciousness as the outcome of existence, and not conversely,

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[115] Karl Marx, *Capital: A Critique of Political Economy*, Volume I: Book One: The Process of Production of Capital, 'Afterword to the Second German Edition,' translated by Samuel Moore and Edward Aveling, proofed by Dave Allinson (Moscow: Progress Publishers, 2015), 10. See also: www.marxists.org

[116] Vladimir I. Lenin, *The teachings of Karl Marx*, Vol. 1 (New York: International Publishers, 1935) 13.

[117] Cited by Lenin in *The teachings of Karl Marx*, 13.

[118] Stalin in 'Dialectical and Historical Materialism,' (p.7) notes that, "It does not follow from Marx's words, however, that social ideas, theories, political views and political institutions are of no significance in the life of society, that they do not reciprocally affect social being, the development of the material conditions of the life of society. We have been speaking so far of the origin of social ideas, theories, views and political institutions, of the way they arise, of the fact that the spiritual life of society is a reflection of the conditions of its material life. As regards the significance of social ideas, theories, views and political institutions, as regards their role in history, historical materialism, far from denying them, stresses the important role and significance of these factors in the life of society, in its history. There are different kinds of social ideas and theories. There are old ideas and theories which have outlived their day and which serve the interests of the moribund forces of society. Their significance lies in the fact that they hamper the development, the progress of society. Then there are new and advanced ideas and theories which serve the interests of the advanced forces of society. Their significance lies in the fact that they facilitate the development, the progress of society; and their significance is the greater the more accurately they reflect the needs of development of the material life of society." See: Karl Marx and Frederick Engels, *Selected Works* in three volumes, Volume I, (Moscow: Progress Publishers, 1976), 269.

materialism must explain social consciousness as the outcome of social existence.[119] Human consciousness is crucial in Marx's thought, but it can only be understood in relation to historical, social, and material circumstances or conditions.[120] Marx and Engels were materialists. When describing their materialism, Marx and Engels usually refer to Feuerbach as the philosopher who restored materialism to its rights.[121] Marx took Feuerbach's materialism and developed it into a scientific-philosophical theory of materialism. According to Fine and Saad-Filho,

> [Marx], criticized Feuerbach for seeing people as individuals struggling to fulfill a given 'human nature,' rather than as social beings. However, he soon moved beyond Feuerbach's materialism…he extended Feuerbach's materialist philosophy to all dominant ideas prevailing in society, beyond religion to ideology, and people's conception of society as a whole…he [also] extended Feuerbach's to history. Feuerbach's analysis had been entirely ahistorical and non-dialectical.[122]

Lenin maintains that, Marx and Engels pointed out the shortcomings of Feuerbach's materialism.[123] Having introduced the contributions of both Hegel and Feuerbach to the development of Marxism, below is an exposition of dialectical materialism.

2.7 Dialectical materialism

Dialectical materialism is the philosophy of Marxism-Leninism. Its approach and its method of studying is dialectical, its theory is materialistic. Historical materialism extends from the principles of dialectical materialism to the study of social life, it applies the principles of dialectical materialism to the life of society, to the study of society and of its history.[124] Lenin states that, "historical materialism first made it possible to study with scientific accuracy the social conditions of the life of the masses and the changes in these conditions."[125] Lenin further asserts that,

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[119] Lenin, *The teachings of Karl Marx*, 15.

[120] Ben Fine and Alfredo Saad-Filho, *Marx's Capital* (6th edition) (London: Pluto Press, 2016), 3.

[121] Refer to Karl Marx and Friedrich Engels (1855-56), *Collected Works*, Volume XIV, (London: Lawrence & Wishart, 2010) 652-54.

[122] Fine and Saad-Filho, *Marx's Capital*, 2.

[123] Lenin, *The teachings of Karl Marx*, 12.

[124] Joseph V. Stalin, entitled: 'Dialectical and Historical Materialism,' published in September 1938, 1. A digital copy may be retrieved from: marxistphilosophy.org/stalin1938.pdf.

[125] Vladimir I. Lenin, *The teachings of Karl Marx*, Vol. 1 (New York: International Publishers, 1935), 16.

> [Dialectics] includes what is now called the theory of cognition, or epistemology, or gnoseology, a science that must contemplate its subject matter in the same way – historically, studying and generalizing the origin and development of cognition, the transition from non-consciousness to consciousness.[126]

The strength and vitality of dialectical materialism lies in the fact that it bases its practical activity on the needs of the development of the material life of society and never separates itself from the real life of society.[127] This separation between reality (content) and the way it appears (form) is a central aspect of Marx's dialectical thought.[128] Marx establishes a close relationship between dialectics and history, which would become a cornerstone of his own method.[129] Consciousness is primarily determined by material conditions but these themselves evolve dialectically through human history.[130] Engels affirms that,

> [In] dialectical philosophy, nothing is established for all time, nothing is absolute or sacred. On everything and in everything it sees the stamp of inevitable decline; nothing can resist it save the unceasing process of formation and destruction, the unending ascent from the lower to the higher – a process of which that philosophy itself is only a simple reflection.[131]

Marxism points the way to a comprehensive, an all-embracing study of the rise, development, and decay of socio-economic structures.[132] It is a structure of ideas and a structure of power. Therefore, it is important to rethink the meaning of Marxism-Leninism and the possibilities of the socialist tradition. In the structure of Marxist-Leninist ideas political philosophy derives from economic interests. Lenin suggests that,

> [There is] a complex network of social relations and *transitional stages* between one class and another, between the past and the future, [that] Marx analyzes in order to arrive at the resultant of the whole historical development. Marx's economic doctrine is the most profound, the most many-sided, and the most detailed

[126] Lenin, *The teachings of Karl Marx*, 14.

[127] Stalin, 'Dialectical and Historical Materialism,'7.

[128] Ben Fine and Saad-Filho, *Marx's Capital* (6th edition) (London: Pluto Press, 2014), 3.

[129] Fine and Saad-Filho, *Marx's Capital*, 3.

[130] Fine and Saad-Filho, *Marx's Capital*, 3.

[131] Cited by Lenin in the *Teachings of Karl Marx*, 13

[132] Lenin, *The teachings of Karl Marx*, 16.

> confirmation and application of his teaching.[133]

The canonical version of dialectical materialism is set out in Marx's *Critique of Political Economy* and subsequently elaborated upon by many Marxist-Leninists. Howard and King, in their exposition of Marxism-Leninism, make a reflective contribution to theoretical discourse on dialectical materialism as a theory of change. Howard and King assert that,

> [Dialectical] materialism is a theory of economic, political and cultural structures, and their mechanisms of change, rather than narrative history. In other words, dialectical materialism is coarse grained. While historical paths are sequences of events and actions, [dialectical] materialism is not much concerned to describe what they are, beyond explaining their general type and overall trajectory.[134]

Dialectical materialism, as a theory of social and economic structures and their mechanisms of change, sheds light on the problem of the conditions of the poor and the working-class.[135] It allows for an understanding of the exploitation of the working-class as part of a general system of exploitation.[136] Marx claims that in capitalism the workers are exploited because they produce more value than they appropriate through their wage; this gives rise to surplus value.[137] This conclusion sheds light on capitalism as a mode of production and exploitation. The importance of dialectical materialism lies in going beyond the limits of theories, instead places facts in their social and economic context.[138] The capitalist system as a mode of production and exploitation forms society into various orders/sub-systems – various classes, others sub-ordinate to the other. The working-class provides the labour power and is subordinate to the capitalist class. The principal claim is that the social (class) relations that define the economic system, and the institutions of politics and law, as well as dominant forms of social consciousness, are all ultimately determined by the requirements of the productive forces (or forces of production).[139] The concept of forces of production is used to refer to the means of production to which labourers add value and transform capital into products/services (for sale). The productive relations (relations of production) are relations of power, and generally also

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[133] Lenin, *The teachings of Karl Marx*, 18.

[134] Michael. C. Howard and John. E. King, *The rise of neo-liberalism in advanced capitalist economies: a materialistic analysis*, (London: Palgrave, 2008), 43.

[135] Thomas Sankara, *Thomas Sankara Speaks* (Cape Town: Pathfinder Press, 1988), 262.

[136] Sankara, *Thomas Sankara Speaks*, 262.

[137] Fine and Saad-Filho, *Marx's Capital*, 5.

[138] Sankara, *Thomas Sankara Speaks*, 263.

[139] Howard and King, *The rise of neo-liberalism in advanced capitalist economies: a materialistic analysis*, 40.

take the form of ownership of the productive forces.[140] The productive forces consist of the means of production and labour power. In such a system, what is the meaning of "means of production" as a concept? How should the concept be understood? The means of production are physical, non-human inputs used to produce economic value. The means of production are raw materials, space and instruments of production, the latter including tools, machines (technology), premises (facilities) and instrumental materials.[141] On the other hand, labour power are those who sell their labour to others (the proletariat). Engels maintains that, labour power is taken to mean the productive abilities of producing agents, comprising their strength, their knowledge and their inventiveness.[142] The productive relations (or relations of production) constitute the economic structure of the economic system. This is contrasted with the superstructure, which consists of all those non-economic institutions whose character is crucial to the functioning of the economic system, the legal system and the state.[143]

Thus, to be a capitalist is to have a social status in production. However, capital is a collective product. Only by the united action of all members of society, can it be set in motion. Therefore, capital is not personal. It is an economic and social class power that has a political implication. Capital (founded on private gain and exploitation) is independent and has both individuality and collectivity; but most importantly, it also has class character. Jurisprudence is but the will (determined by economic conditions) of the capitalist class made into law for all. As a result, new markets are created; new industries are created and monopolized. The markets keep on growing and demand keeps on rising. A class of millionaires and billionaires is created, and a world market established, giving immense development to commerce. In proportion, the capitalists develop and increase their capital. On the other hand, a free labour market conceals exploitation; its existence reproduces the privilege and power of the capitalist class, whilst the material conditions of the proletarian class and the poor are reproduced for their continuing reproduction. Capitalists coerce the poor masses, as a class, into the background, periphery,

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[140] Howard and King, *The rise of neo-liberalism in advanced capitalist economies: a materialistic analysis,* 40.

[141] Howard and King, *The rise of neo-liberalism in advanced capitalist economies: a materialistic analysis,* 40. In the current neoliberal economic system, there remains a monopoly of the means of production by a small, capitalist, white minority. The ownership of the means of production and of property, in the healthcare industry are centralized (conglomerated) and concentrated in the hands of the few (a white minority). Private property relations are the pre-condition for the existence of capital and its rule.

[142] Howard and King, *The rise of neo-liberalism in advanced capitalist economies: a materialistic analysis,* 40.

[143] Howard and King, *The rise of neo-liberalism in advanced capitalist economies: a materialistic analysis,* 40.

and margins of society.[144] The capitalists through the exploitation of the world market have given a cosmopolitan character to production and consumption in every country. Fine and Saad-Filho suggest that,

> [Only] detailed analysis can offer valid insights about [the] internal structure, workings, contradictions, changes, and limits [of human societies]. In particular, Marx considers that societies are distinguished by the mode of production under which they are organized…Each mode of production is structured according to its class relations for which there are appropriate categories of analysis…Societies are distinguished by the modes of production and their modalities of surplus extraction.[145]

It is a social power to exploit the proletarian class. The post-modern capitalists are in themselves the product of a long course of a historical development of capitalism as an exploitative economic system. Moreover, each step in the development of capital is accompanied by a corresponding political (and non-economic) advance of another class: a proletarian class.[146] Therefore, the capitalist system is split-up into two great hostile camps, into two great classes directly facing each other – in collision: capitalist class and proletariat (working class, a class of wage labourers – who live so long as they find work, and who find work so long as their labour increases capital). Marx felt it necessary to explain that the monopoly of the means of production (raw materials, machinery, factory buildings, and so on)

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[144] In South Africa, there remains a class of capitalists who are owners of the means of production (both social and economic means of production). By proletariat, Oliver Tambo meant the majority of the people living in South Africa (the African majority) are in a class of wage labourers (working class, who must sell themselves piecemeal, and are reduced to a commodity, like every other article of commerce) who having no means of production of their own are reduced to selling their labour power in order to live. Tambo maintained that, "In our situation, we have to attach equal importance, at this stage, to organizing the exploited workers, organizing the oppressed masses. Therefore, we operate on three fronts: the labour front, the front of mass popular actions, as well as the front of armed actions…Over the years we have developed this organic link and we think that they knit together to constitute a force which the enemy will find very difficult to contain." Taken from speeches, letters and transcripts from the compilation compiled by Adelaide Tambo: *Oliver Tambo Speaks* (Cape Town: Kwela), 256. Oliver Tambo takes his concepts from Frederik Engels in *The condition of the working-class in England: From personal observation and authentic* sources, were Engels says that, "The modern class of wage-workers who possess nothing but their labor-power and can live by only by the selling of that labor-power to others" (Moscow: Progress Publishers, 1892), 19.

[145] Fine and Saad-Filho, *Marx's Capital*, 5.

[146] Classic political economists at times take for granted the racialized and capitalist features of South African society. Moreover, the nature of capitalism in South Africa is characterized by racialized social and economic inequalities, wherein the majority are African and poor and are unemployed (with a precarious livelihood).[146]

by a small minority, the wage employment of the majority, the distribution of the products by monetary exchange, and remuneration involving the economic categories of process, profits, interest, rent, wages, fees and transfers are features of a capitalist society.[147] In addition, for Marx and the whole Marxist-Leninist tradition, it was evident that the interests of these two basic classes of contemporary society were irreconcilably opposed. The capitalists are obliged to maximize their profits. This means that they have to depress wages to a minimum. By contrast, the proletarians seek to maximize their wages, welfare, and security at the cost of capitalist profits. These two groups are set in hostile opposition one to the other. They are "opposites." One seeks to preserve capitalist power structures. The other seeks to overthrow capitalism.

Hence, the history of society is a history of class struggle. The history of society consists of the development of class antagonisms that assume different forms at different epochs.[148] Capitalists (owners of the means of production) and proletariat (sellers of the their labour power) have stood in constant opposition to one another, carried on an uninterrupted, now hidden, now open fight, a fight that ends in a revolutionary reconstitution of society at large, but also in a common ruin of the struggling classes.[149] Engels asserts that, "According to Marx, the cause of the present antagonism of the classes and of the social degradation of the working-class is their expropriation from all means of production, in which the land is of course included."[150] The proletariat (organized as a class) is to use its political supremacy to wrestle

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147 Fine and Saad-Filho, *Marx's capital*, 10.

148 Karl Marx and Friedrich Engels, *The communist manifesto*, 15th printing, translated by Samuel Moore and edited by Joseph Katz (New York: Washington Square Press, 1977), 92.

149 Marx and Engels, *The communist manifesto*, 58. The political philosophy of liberation in South Africa towards the democratic transition in 1994 was inspired by classical Marxism. Towards the 1990s there was a majority view in South Africa that the racist oppressive regime and NP-led capitalist state must be destroyed and replaced by a democratic state. Oliver Tambo once said that, "Our country is highly industrialized. The oppressed population is the proletariat, the working people. The struggle for liberation is a struggle of the workers who constitute the proletariat. They constitute the most powerful contingent in our struggle, and we have had to devote attention to their organisation and mobilization. It is clear to us, as it is clear to the enemy, that it is not enough to have a militant working class: it has to be well organized. This process of organisation is developing rapidly. And it is clear to us, as it is to the enemy, that the workers, the black workers especially, constitute a force that could pose a serious threat to the regime." See compilation of Tambo's speeches by Adelaide Tambo, *Oliver Tambo Speaks*, (Cape Town: Kwela), 256.

150 Frederik Engels in *The condition of the working-class in England: From personal observation and authentic* sources (Moscow: Progress Publishers, 1892), 20. The means of production within the healthcare sector and the means of exchange are the foundation in which the bourgeoisie (capital – owners of the conglomerate healthcare sector) are building themselves up within a context of free competition, accompanied by a social and political constitution adapted to it. Engels (in *The condition of the working-class in England: From personal observation and authentic* sources, p.20) continues to

all capital from the capitalists and to centralize all instruments and means of production in the hands of the state and to increase the totality of productive forces as rapidly as possible.[151] But, class antagonisms remain, and the supremacy of the capitalist class has not been overthrown. The conditions for the existence of class antagonisms and of classes generally have not been abolished. Such conditions have established new classes such as the middle-class. Yet, the middle-class sinks gradually into the proletariat – their diminutive capital does not suffice to be in competition with large capitalists. However, there are new conditions of exploitation and new forms of struggle in place of the old ones.

2.8 Comparison between Marxism and the HRBA

Dialectical materialism contemplates its subject matter historically and materially studying its origins, development and transitions. A materialist approach takes into consideration the social and economic conditions of the life of the poor and proletarian masses and the changes in these conditions. According to a dialectical materialist approach there is no equality in interaction between the two antagonistic classes (proletarian and capitalist). One class depends on the other in a mode of production that is not interdependent but exploitative. By comparison, the HRBA agrees with the principles of interdependence and equality but does not elucidate clearly the idea of exploitation of one class by another. Yet, in the South African context such exploitation is racialized. Unfortunately, human rights philosophy fails to provide a framework for a clear analysis of racialized exploitation. Dialectical materialism, on the other hand, bases its activity on the needs of the development of the material life of society and never separates itself from the real life of society. It can frame exploitation within the context of relations of production.

The result of a racially exploitative capitalist system is social action – to improve living conditions, thereby improving healthcare systems for the poor. Social inaction restricts and

say that, "[If] land-monopolization [is declared] to be the sole cause of poverty and misery…the remedy [is] in the resumption of the land by society at large. Now the Socialists of the school of Marx, too, demand the resumption, by society, of the land, and not only of the land but of all other means of production." Mao Tsetung, *Quotations from Chairman Mao Tsetung* (Beijing, Foreign Language Press, 1974) in a speech at the Chinese Communist Party's National Conference on Propaganda Work (12 March 1957) cited from the 1st pocket edition (p.26-27) holds that, "In the ideological field, the question of who will win in the struggle between the proletariat and the [capitalists] has not been really settled yet. We still have to wage a protracted struggle against [capitalist] ideology. It is wrong not to understand this and to give up ideological struggle." In p.19, Mao said that, Maoism further holds that, "[Capitalist] ideology, anti-Marxist ideology, will continue to exist for a long time. Basically, the socialist system has [not yet] been established…We have [not] won the basic victory in transforming the ownership of the means of production…we have not won victory on the political and ideological fronts."

[151] Marx and Engels, *The communist manifesto*, 93.

prevents the development of healthcare systems amongst the poor and the working-class in the population. In this context, dialectical materialism holds that health is socially determined, and to a large extent it is determined by the material conditions such as the conditions of housing; access to clean water and sanitation systems; living standards and basic income that is sufficient to ensure adequate nutritional intake; education and equitable access to health resources when needed; including immunisation against preventable disease. By contrast, the HRBA subjugates these basic human needs to market forces by building a sustainable movement for equality of participation and parity, including non-discrimination against the private healthcare sector. It provides a framework for an ideological shift away from de-commodification and de-commercialization of healthcare and towards a fulfilment of healthcare as a right.

In the HRBA, as a methodological framework, healthcare is commodified and commercialized. For example, human rights principles that include social solidarity do not take into consideration a racialized and exploitative economic structure of society; wherein healthcare is commodified in a market system that is owned and controlled by a minority. Instead, a HRBA claims "universality" and "equity" and does not frame these claims within an analysis of political and economic class interests. It frames these claims within a moral philosophy of responsibility and choice. As such, the HRBA places emphasis on human rights implementation through human rights principles of non-discrimination and participation. Yet, the implication is that the HRBA provides a frame to argue that the private sector, owned by a capitalist class, cannot be discriminated against with regards to its participation in the healthcare economy. The problem is that the exclusion of the private sector is seen as a human rights violation when using the HRBA as a lens. The private corporation assumes the rights of a person. Yet moral philosophy is not transferrable to the legal non-human person. The rights that apply to a human person (human rights) cannot apply to a private juristic (legal) person (non-human rights). The HRBA as a framework justifies the claim that they do apply, and that creates a problem with the framework.

The public healthcare system offers healthcare for free to the majority of the population who are poor and working-class; whilst the private healthcare system provides healthcare at an expensive cost to a minority in the population who mainly comprise the middle-class. The two systems are unequal and not the same. To state that there cannot be equality of participation by the two healthcare systems in one economic system does not mean a prejudicing of the private sector and thereby a violation of its rights. That is the problem with using the HRBA in practice, it does not separate the content of the private healthcare system from its form, and creates

apologists for the private healthcare sector. The HRBA has no class consciousness. Yet, class consciousness is a central aspect of dialectical thought. Marxism establishes a close relationship between dialectics and history and in the Marxist method class consciousness is determined by the material conditions which evolve dialectically through history. The dialectical evolution of the private and public healthcare system in South Africa has occurred historically. Its relationship has been established given the South African racial origins of the private healthcare system and South Africa's colonial and apartheid history.

The material conditions of the poor majority that the NHI system is targeting have not yet structurally changed since the democratic transition, they evolve dialectically with the material conditions of the white minority as both a race and class that owns and monopolizes the means of healthcare provision through private healthcare conglomerates. In this context, particularly in South Africa the adoption of the rhetorical power of human rights and the HRBA has no class content. This is due to the fact that human rights are a set of legal standards, thereby forming a part of the superstructure, a legal system that protects a capitalist system. The HRBA determines how these legal standards and obligations should be achieved and substantiates this in legal and political analysis. But such legal standards are not absolute or sacred. The private healthcare sector in South Africa, which currently serves a small minority (8%), yet utilizes government funds to sustain itself, is not absolute, neither is it sacred, it must be dismantled and negated. Marxism sees in it an inevitable decline.

As the price for healthcare provision rises and healthcare insurance becomes unaffordable, the demand for private healthcare services is in a decline. Hence, the private healthcare sector incessantly and continuously lobbies the government and state officials so that funds from the NHI Fund be routed to the private healthcare system. This sparks an ideological exchange. In such an exchange, one view, based on the HRBA, holds that marshalling the analytical force of the HRBA can help change the terms of the ideological debate, perhaps through policy and legislative guidelines that are informed by human rights principles, human rights-based indicators and empirical evidence. However, nothing can resist Marxism in South Africa and its unceasing framework for the process of formation and destruction. For example, through the lens of Marxist-Leninist ideas, one sees that in South Africa the political philosophy underpinning the private healthcare system and the South African political economy within which it is embedded derives from racialized, economic, capitalist class interests. In this context, how the HRBA is implemented appears to have more to do with the mission and objectives of agencies of non-state actors and organizations. Relatedly, the application of a

HRBA has been adopted by domestic non-state actors active in the field of healthcare and dominant in the private healthcare system. In such a system, there is a complex network of racialized social relations and *transitional stages* between one class and another, one race group (white) and another (black), between the past (apartheid) and the democratic future. Marxism assists in analyzing these features in order to arrive at the resultant of the whole historical development of the two-tiered healthcare system in South Africa.

In the current fragmented and repugnant two-tiered system, private medical insurance agencies/schemes and private healthcare organizations have often improvised in defining for themselves what constitutes a HRBA. Through a HRBA they have implied that people are active subjects with legal claims and that they have a choice to access the private healthcare system on an equal basis using the NHI Fund as a financing mechanism. Hence, private healthcare is in favour of the HRBA as a method of implementing human rights in the healthcare system under the pretext of universal health coverage (UHC). But, dialectical materialism, as a theory of social and economic structures and their mechanisms of change, sheds light on this problem, and brings to the fore the conditions of the working-class and the poor in South Africa, including the conditions of public healthcare facilities that service these classes. It also allows for an understanding of the exploitation of the working-class as part of a general system of exploitation within the private healthcare sector.

Marx claims that in capitalism the workers are exploited because they produce more value than they appropriate through their wage, this gives rise to surplus value (profit). This conclusion, in a context where the private healthcare sector is driven by profit, sheds light on capitalism as a mode of production within which the private healthcare system operates. The capitalists in private healthcare argue that mainstreaming ideas from the HRBA such as "cooperation" (between the public and private system) ultimately aims at achieving key interventions given the context and material conditions of the working-class and the poor, particularly with regards to the lack of healthcare facilities in their areas. However, according to dialectical materialism, there is no "cooperation" in such a context, but "antagonism."

Furthermore, the application of a HRBA does not provide a framework for a discussion of antagonistic productive relations of power that constitute the economic structure of a racialized and capitalist economic system. By contrast, dialectical materialism provides an appropriate framework to show that private healthcare capital in South Africa is founded on private gain and has class character. The HRBA aids the continuation and reproduction of the two-tiered healthcare system. When the private sector is co-opted by the state in the delivery of public

services capitalists shall coerce the poor masses, as a class, into the background, periphery, and margins of their system. Only a Marxist analysis offers valid insights about the internal structure, workings, contradictions, changes, and limits of South Africa as a capitalist society. Marxism considers that societies are distinguished by the mode of production under which they are organized. In South Africa, each mode of production is structured according to its race and class relations and further distinguished by the modes of production and their modalities of profit extraction.

It is a racial, social, political, and economic power to exploit the black proletarian class in South Africa. The capitalists within the private healthcare conglomerates are in themselves the product of a long course of a historical development of capitalism as an exploitative economic system in South Africa. They cannot simply be given NHI funds for their own profit maximization. Neither should they be benefitting from any state-owned funds. Marxism provides a lens to see that the South African capitalist system within which the private healthcare system operates is split-up into two camps, into two classes that are in collision, the capitalist class and the proletarian class (a class of wage labourers who live so long as they find work, and who find work so long as their labour increases capital). Marxism sees it necessary to explain that monopoly capital in the private healthcare system is not only exploitative but has narrow profit interests. By contrast, the HRBA simply holds that the private system is also a *duty bearer* that must be treated as equal to the state. This simple classification lacks a class analysis. The private healthcare sector cannot assume equal rights and corresponding responsibilities to the state in such a manner that the state is also simply reduced to a *duty bearer* that is equal to the private sector.

In Marxism and the whole Marxist-Leninist tradition, it is evident that the interests of the public and the private healthcare systems within contemporary capitalist society are neither equal nor complementary but are irreconcilably opposed. The two systems are "opposites." The private sector as a non-state actor will constantly seek to preserve itself as a capitalist power structure. In the Marxist context, unlike in the context of a HRBA, the history of South African society as a history of race and class struggle continues. Capital remains mainly white. Hence, the history of South African society consists of the development of race and class antagonisms that assume different forms at various times. In South Africa, capitalists (as owners of the means of production) and the proletariat (as sellers of their labour power) have stood in constant opposition to one another, they still are carrying on an uninterrupted yet hidden fight that shall end in a revolutionary reconstitution of South African society.

2.9 How Marxism works in practice

Marx asserts that, "The circulation of commodities is the starting-point of capital."[152] Hence, commodification and commercialization have formed the starting-point of the economic system. In such a system, money is a form in which capital appears. Marx asserts that, "[capital] is the economic power which dominates everything."[153] According to Marx, "The circulation of money as capital is, on the contrary, an end-in-itself, for the expansion of value takes place only within this constantly renewed movement. The circulation of capital; has therefore no limits."[154] Money is a product of exchange. According to Lenin, "Being the highest product of the development of exchange and of commodity production, money masks the social character of individual labour, and hides the social tie between the various producers who come together in the market."[155] Lefebvre maintains that,

> [Analysis of the starting point] determines the relations and moments of the complex content. Only then can the movement of the whole [economic system] be reconstituted and 'exposed'… In thought it appears as a process of synthesis, as a result and not as a starting-point, although it is the true starting-point.[156]

Financial capital formation is the starting point for capitalist production in the development of a commodity.[157] It forms the point of departure and the conclusion.[158] The financial economy and its concepts brings about the interconnection of various conceptual and economic categories. Class as a conceptual category is the ruling material force of society. The class which owns the means of production has control of the financial economy. The financial economic system has undergone a series of recent and controversial changes. Commodities are traded (exchanged) in the market system. Lefebvre points out that,

> The exchange of commodities tends to put an end to a natural, patriarchal economy. In relation to individuals this new social whole, functions as a superior organism. In particular, it imposes on them a division and distribution of labour in conformity

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[152] Marx Selected writings, 445.

[153] James D. White, *Karl Marx and the intellectual origins of dialectical materialism* (London: Macmillan Press, 1996), 162. Citing Karl Marx.

[154] David McLellan, *Karl Marx: Selected writings*, (Oxford: Oxford University press, 2000), 449.

[155] Vladimir I. Lenin, *The teachings of Karl Marx* (Moscow, 1982), 20.

[156] Lefebvre, *Dialectical Materialism*, 75.

[157] Modified from White, *Karl Marx and the intellectual origins of dialectical materialism*, 162.

[158] White, *Karl Marx and the intellectual origins of dialectical materialism*, 162.

with the sum of the forces of production and the requirements of society.[159]

Commodification is the simplest element in capitalist production. However, there emerges a dualism in the political economic system, a mixture of two categories: the public and the private sectors – wherein commodities are presented as a complex of two things – use-value and exchange-value.[160] Hence, financing private interests becomes a continuous challenge; for private interests are a socially determined interest. Therefore, competition in society is indicative of neoliberalism and the discourse of methodological individualism. Such discourse reigns supreme in the legitimation of a "reified" world system; what Lefebvre calls, "the bureaucratic society of controlled consumption."[161] In such a society, differentiations, alignments and antagonisms in so far as they influence class formation cannot be fully grasped unless they are situated within the process of class conflicts operating on complex levels in an evolving capitalist system.[162] Lefebvre asserts that, "The materialist dialectic necessarily gives the [two] categories an essential role to play. They have their own truth in themselves, without needing to be attached to the concept in general and its purely logical development. [They] are specifically economic categories."[163] Such economic categories relate to form a two-tiered system (public and private) that offers certain products. Lefebvre suggests that, "A product of practical activity, answers to a practical need; it has a use-value."[164] Marx asserts that, "The utility of a thing gives it use-value;"[165] and that "The use-values of commodities furnish the material for a special study, that of the commercial knowledge of commodities."[166] Lenin maintains that,

> A commodity is, firstly, something that satisfies a human need; and secondly it is something that is exchanged for something else. The utility of a thing gives it use-value. Exchange-value (or simply, value) presents itself first of all as the proportion, the ratio, in which a certain number of use-values of one kind are exchanged for a certain number of use-values of another kind.[167]

[159] Lefebvre, *Dialectical Materialism*, 77.

[160] McLellan, *Karl Marx: Selected writings*, 425.

[161] Juan Jr., 'Marxism and the race/class problematic: a re-articulation,' 2.

[162] Juan Jr., 'Marxism and the race/class problematic: a re-articulation,' 2.

[163] Lefebvre, *Dialectical Materialism*, 77.

[164] Lefebvre, *Dialectical Materialism*, 77.

[165] McLellan, *Karl Marx: Selected writings*, 421.

[166] McLellan, *Karl Marx: Selected writings*, 421.

[167] Vladimir I. Lenin, *The teachings of Karl Marx*, (Moscow), 18.

Lenin in the above quotation echoes Marx. Marx asserts that, "Use-values become a reality only by use or consumption; they also constitute the substance of all wealth, whatever maybe the social form of that wealth."[168] Thus, a crucial feature of capitalism is that it is a highly developed system of commodity production.[169] Marx says that, "As use-values, commodities are, above all, of different qualities, but as exchange-values they are merely different quantities, and consequently do not contain an atom of use-value."[170] Lefebvre, such as Marx and Lenin, distinguishes use-value from exchange-value within a commodity: their usefulness, which cannot be quantified in general, from the ability to exchange with other commodities, which can be quantified.[171] Lefebvre further holds that, "Use-values and the labour of living individuals are qualitative and heterogeneous. Exchange-value and social labour are quantitative. This quality and quantity are connected yet distinct and interact [with] one another. Exchange-value is measured quantitatively: its specific measure is the currency [money]."[172] Therefore, if a product or service is provided at a fee, this means that it is commodified; then if it is exchanged for money, it is commercialized – it has exchange-value. When a product in the economic system is free, it means that it is not exchanged for money, it is de-commercialized – it is a use-value. Thus, it is de-commodified; since not every use-value is a commodity.[173] In this framework, for any product (commodity) or service (commodified) that had been previously exchanged for money (commercialized) to be free, and no longer traded in the market system, it requires that it be de-commercialized (not be sold) and de-commodified (not be treated as a commodity to be sold in the market system).

Marxism points out that, particular products and services can be offered for free by public institutions, though they be products of human labour, such products and services need not be treated as commodities to be traded in the market system.[174] The important question becomes one of finance for particular products and services that must be provided (for free, for all in society). The social, political, and economic vision of Marxism is to create an equal and just society. Yet, the conglomerate private sector and the state bureaucracy confers, to particular products and services, that are meant to be free for all in society, a second existence: their value

[168] McLellan, *Karl Marx: Selected writings,* 421.

[169] Fine and Saad-Filho, *Marx's Capital,* 15.

[170] McLellan, *Karl Marx: Selected writings,* 423.

[171] Fine and Saad-Filho, *Marx's Capital,* 15.

[172] Lefebvre, *Dialectical Materialism,* 78

[173] Fine and Saad-Filho, *Marx's Capital,* 15.

[174] McLellan, *Karl Marx: Selected writings,* 425.

is duplicated (in the two-tiered system – in both the private sector and the public sector) into use-value and exchange-value. In the public sector – there are use-values for some (fee-free) and not for others (fee-charged) – others must pay. In the private sector – exchange-value for all – all must pay (an expensive fee or exorbitant fees). Lefebvre further suggests that, in the first place then, exchange-value has a historical reality, at particular points in time it has been the dominant and essential category in the market economy.[175] Regarding the market economy in relation to commodities, Marx asserts that,

> The production of commodities, their circulation, and that more developed form of their circulation called commerce, these form the historical groundwork from which [capital] rises. The modern history of capital dates from the creation in the sixteenth century of a world-embracing commerce and a world-embracing market.[176]

Therefore, in the context of a world-embracing (global) market economy what is notable in the conglomerate private sector is: commercialization – buying and selling (trading and investment in the market system). Lefebvre asserts that, "[It] is in modern society that commerce – buying and selling – has reached its greatest possible extent. Like it or not the activity of individuals is exercised within this framework, collides with these limits, and assists in the continual creation of this fundamental category."[177] Products and services in a capitalist market economy are purchased at an expensive cost. As a result of a neoliberal market economy, all products and services are both commodified and commercialized. Marx asserts that,

> When commodities are exchanged, their exchange-value manifest itself as something totally independent of their use-value. But if we abstract from their use-value, there remains their [value]…Therefore, the common substance that manifests itself in the exchange-value of commodities, whenever they are exchanged, is their value.[178]

According to Lefebvre, these two aspects of value (use-value and exchange-value) are never completely separate, yet they are distinct and contradictory.[179] In and through exchange,

[175] Lefebvre, *Dialectical Materialism,* 81.

[176] McLellan, *Karl Marx: Selected writings,* 445.

[177] Lefebvre, *Dialectical Materialism,* 81.

[178] McLellan, *Karl Marx: Selected writings,* 423.

[179] Lefebvre, *Dialectical Materialism,* 77.

producers cease to be isolated; they form a new social whole, the exchange of commodities.[180] Lefebvre suggests that,

> Once launched on its existence the [commodity] involves and envelops the social relations between [people]. It develops, however, with its own laws and imposes its own consequences, and then [people] can enter into relations with one another only by way of products, through commodities and the market, through the currency and money.[181]

This complex reality situates the dialectic between private and public service providers. Lefebvre further suggests that,

> [Such] categories are abstract, [since] they are elements obtained by the analysis of the actual given content, and inasmuch as they are simple general relations involved in the complex reality. But there can be no pure abstraction. The abstract is also concrete, and the concrete, from a certain point of view, is also abstract. All that exists for us is the concrete abstract.[182]

Marx worked out his conception of the dialectic still more thoroughly.[183] In such a two-tiered "concrete abstract" system, there are economically active "personnel" (labour) who are alienated insofar as their multiple faculties are torn apart by proletarianization, class society, money, state, and ideology.[184] The principle of individualism is the governing framework in the private-sector. However, there are close linkages between the public and the private sectors. It is with this double reality that the two systems are linked together and return dialectically into the total movement of the political economic and financial system.[185] To ask a Marxist question: what is common between the two sectors which are constantly weighed one against the other in a dual, two-tier, economic system? Contextually, Marxism provides an answer: that which is common to both sectors is that – whatever is produced is a *product of labour*.[186] Hence, Lenin suggests that,

> The element common to all commodities is not concrete labour in a definite branch

[180] Lefebvre, *Dialectical Materialism,* 77.

[181] Lefebvre, *Dialectical Materialism,* 80.

[182] Lefebvre, *Dialectical Materialism,* 76.

[183] Lefebvre, *Dialectical Materialism,* 76

[184] Lefebvre, *Dialectical Materialism,* xxiii.

[185] Lefebvre, *Dialectical Materialism*, 77.

[186] Lenin, *The teachings of Karl Marx,* 19.

> of production, not labour of one particular kind, but *abstract* human labour – human labour in general. All the labour power of a given society, represented in the sum total of values of all commodities, is one and the same labour power.[187]

The characteristic feature of the capitalist system is that it transforms labour into *abstract* labour. The private sector makes its profits (surplus-value) by producing products and services (as commodities for sale) through *abstracting* labour. What makes these (products and services) capable of being bought and sold is the fact that besides being specific types of commodities and having a particular use-value, they have the characteristic of being worth something in the market, they have exchange value. Therefore, Lefebvre points out that,

> The exchange-value of a product (and the currency is one of these products) is measured by the quantity of social labour it represents. The duplication of value into use-value and exchange-value therefore develops into a complex dialectic, in which we find once again…the unity of opposites and the transformation of quality into quantity and quantity into quality.[188]

Whereas use-value is particular and concrete, exchange-value is universal and abstract.[189] Therefore, money is a universal commodity. Thus, according to Lefebvre,

> [Producers] and groups of producers, in each branch of production, must work in accordance with social demand. If the production of a particular group does not correspond to a demand, or if the productivity of this group falls too far below that of society in general, it is automatically eliminated by its competitors.[190]

For dialectical materialism, the central reference point is not only the internal movement of the economic system but economic praxis, that is the total activity, action and thought, physical labour, and knowledge. Privatization is not an isolated proposition. Neither is it absolute. The capitalist production of a commodity is a system of social and economic relationships in which different competitors (as producers) offer the same kind of service through a socioeconomic division of labour, and in which commodities are commercialized.[191] As a result, the moments of transformation within the political economic system that define dialectical movement

[187] Lenin, *The teachings of Karl Marx*, 19.

[188] Lefebvre, *Dialectical Materialism,* 78.

[189] White, *Marx and the intellectual origins of dialectical materialism*, 163.

[190] Lefebvre, *Dialectical Materialism,* 78.

[191] This idea is developed from Lenin.

become part of the struggle and contradictions of this actuality.[192] Therefore, dialectical logic transcends static assertions and does not reject the principle of separate identity, it gives it content.[193] Lefebvre further maintains that,

> Dialectical logic goes further and asserts: If we consider the content, if there is a content, an isolated proposition is neither true nor false; every isolated proposition must be transcended; every proposition with a real content is both true and false, true if it is transcended, false if it is asserted as absolute.[194]

Dialectical logic, because it determines the content, has quite different implications. In every concrete content, we must discover the negation, the internal contradiction, the immanent movement, the positive and the negative.[195] Once the contradictions have become unbearable in a market society, the need to transcend them becomes stronger than any resistance.

2.10 An emerging methodology from the analysis of Marxist principles

A methodological framework emerges from an analysis of Marxist principles. The present study should be understood in light of the following framework:

South Africa as a market society is an unequal, unjust and divided society. It is divided by race, class, ethnicity, income, location, and property relations. In such a society, there are racialized inequalities of wealth and power. The inner contradiction of South African society is that it is dominated by the neoliberal paradigm of privatization; hence, the conglomerate private ownership of the means of production is embedded within an exploitative system where labourers are commodified, were healthcare workers are regularly hired and exploited in private as wage workers and salary earners that produce commodities for sale for the profit maximization of the owners. Capitalism becomes a continuous mode of production in a market society. Lefebvre affirms that,

> The law of equilibrium of this market society emerges brutally from the general contradiction between producers – their competition. The process which duplicated value into use-value and exchange-value also duplicated human labour. On the one hand, there is the [individual] labour of [skilled] individuals [that have expertise],

[192] Lefebvre, *Dialectical Materialism,* xx.

[193] Lefebvre, *Dialectical Materialism,* 26.

[194] Lefebvre, *Dialectical Materialism,* 30.

[195] Lefebvre, *Dialectical Materialism,* 30.

on the other [the] social labour [of unskilled labourers].[196]

Lefebvre suggests that the unity of the contradictories is not only an interpenetration of concepts, it is also a struggle, a dramatic relation between energies which are only by virtue of one another and cannot exist except one against the other.[197] Therefore, capitalism in South Africa is not merely a system of commodity production, but also, more crucially, it is a system of wage labour.[198] Capitalist production starts with the purchase of labour power as a particular type of commodity. This shows that no system of privatization of property as a reality can remain 'in-itself,' that is isolated, detached, or protected (from becoming negated).[199] Negation is a refusal of existence.[200] The socialization of privately-owned means of production, and the nationalization of private companies becomes real. But where are we to place negation in the healthcare economy? Having gathered together the means of production and labour power there needs to be a reorganization and supervision of the healthcare production process in its entirety by the state. The resulting outcome shall be de-commercialization where de-commodified healthcare products and healthcare services are not "for sale" in the market system. For negation is a category that annihilates a being, cause it to be thrown back into non-being.[201] It is annihilation (*nihilo*). Privatisation of healthcare needs to be negated, and there needs to be a removal of the slightest negativity from the negation of the private sector in the healthcare economy. Hence, the inevitability of de-commodification and de-commercialization in such a context. The negation of privatization (private-ownership) in a particular system means the refusal that the private healthcare sector continues to co-exist with the public sector (state-ownership) in the national healthcare economy. Dialectical unity is not a confusion of the contradictory terms as such, but a unity which passes through the contradiction and is re-established at a higher level.[202] The resultant is a creation of a *unified* system (one sector), a single system.

Lefebvre notes that, "The study of economic phenomena is not an empirical one, it rests on the dialectical movement of the categories. The basic economic category – exchange-value – is developed and, by an internal movement, gives rise to fresh determinations: abstract labour,

[196] Lefebvre, *Dialectical Materialism,* 78.

[197] Lefebvre, *Dialectical Materialism,* 93.

[198] Fine and Saad-Filho, *Marx's Capital,* 28.

[199] Lefebvre, *Dialectical Materialism,* 21.

[200] Jean-Paul Sartre, *Being and Nothingness: An essay on phenomenological ontology* (London: Routledge, 2003), 35.

[201] Sartre, *Being and Nothingness: An essay on phenomenological ontology, 35.*

[202] Lefebvre, *Dialectical Materialism,* 27.

money [and] capital."[203] Dialectical materialism's aim is nothing less than the rational expression of the praxis, or the actual content of life and correlatively, the transformation of the present praxis into a social practice that is conscious, coherent, and free. Its theoretical aim and its practical aim, knowledge and creative action, cannot be separated.[204] Economic conditions in the first place transform the masses (of people) into employed workers (a working-class) and unemployed workers (a poor, unemployable class). The domination of capital in the South African economy creates the common material situation and common interests of this class. The interests which they defend are class interests. In the Marxist optic, class is relational to the means of production.[205] Therefore, social class in a Marxist construal denotes groups of social agents defined principally but not exclusively by their place in the labour process.[206] For the workers to maintain their existence, the only commodity available to sell is their labour power, and this is exchanged for wages (or salaries).[207] Labour power is a historical requisite in the political economic system (and in the genesis of capital).

Class becomes only one aspect or factor in explaining any dynamic in the South African social and economic situation, race being the main factor. The Marxist concept of class galvanizes into a relation of group antagonism (more precisely, class conflict) – the distinctive characteristic of the social totality of capitalism. In South Africa, race and class signifies an element of identity – a phenomenon whose meaning and value becomes incomplete without considering other factors such as gender, location, and income. The activity of any production and its related labour (whether it is understood in terms of the specialized labour of the skilled workers, and the creative aspects of production) is not overlooked, neither is a historically specific, capitalist notion of production *accepted* as a trans-historical given.[208] Negation is stripped of all negative function. The state may guarantee access to a healthcare services, by providing them itself for *free* throughout the country. Such services cannot be offered for free by the state by using the private sector institutions for the delivery of such services. Private sector activities should not be permitted to exist in certain sectors of the political economy, particularly healthcare.

[203] Lefebvre, *Dialectical Materialism,* 83.

[204] Lefebvre, *Dialectical Materialism,* xxi.

[205] Juan Jr., 'Marxism and the race/class problematic: a re-articulation,' 7.

[206] Juan Jr., 'Marxism and the race/class problematic: a re-articulation,' 7.

[207] Fine and Saad-Filho, *Marx's Capital,* 29.

[208] Lefebvre, *Dialectical Materialism,* xxii.

2.11 Conclusion

This chapter gave a brief background to human rights philosophy and considered the main components, and common characteristics of a human rights-based approach (HRBA) as a methodological framework. In the chapter, I gave an exposition of the HRBA and dialectical materialism (Marxism) as methodological frameworks. I clarified how both methodological approaches work in practice and showed that the weakness of the HRBA lies in being a methodological framework that excludes an analysis of the complex interconnections between race and class, capital and labour. The next chapter gives background to the ideological origins of privatization of healthcare in South Africa. It shows that towards the democratic transition the apartheid government privatized the healthcare sector and introduced free market-based principles into the healthcare economy.

Chapter 3

Competing ideological perspectives towards the 1990s: an evaluation of its relevance to the question of quality healthcare (an ambiguous legacy)

3.1 Introduction

The previous chapter set out a theoretical framework in terms of which the research questions were clarified and provided an examination of the substantive issues. In it, I explained the methodology to be used in evaluating and analysing the situation regarding the proposed NHI system. This chapter is largely a historical account of the ideological debates within the ANC/SACP regarding *(a)* the nature of the struggle and *(b)* the unfolding thinking on the healthcare system. It gives background to the historical and ideological origins of privatization of healthcare in South Africa. It shows that towards the democratic transition the apartheid government privatized the healthcare sector and introduced free market-based principles into the healthcare economy. Therefore, the idea of healthcare provision being the responsibility of both the public and private healthcare sector pre-dates 1994. It further shows that in the 1990s a debate raged within the African National Congress (ANC) regarding the strategic objective of the ANC. Key to the debate was the question of the *two-stage theory* of the National Democratic Revolution (NDR).

The *two-stage theory* argued that the first stage of the NDR was a revolutionary overthrow of the apartheid government thus taking over "ownership" and "control" of the strategic sectors of the economy after a seizure of power.[1] The second stage of the NDR was to be the introduction of socialism during a democracy. This stage was abandoned by the ANC, and the debate whether the private capitalist economy was to be brought into the "ownership" of the state was unresolved. Exactly what "control" meant was left unclear. Ultimately, the ANC took the option of "compromise," "co-option," "accommodation," and "cooperation" with the

[1] The theory of the NDR originates in Marxism-Leninism, particularly within the context of a Colonialism of a Special Type (CST) thesis in South Africa. It is race and class-focused theory that is historical, and teleological. It deals with the currency of struggle and power under the sign of a socialist telos. See: Daryl Glaser, 'National Democratic Revolution meets Constitutional democracy,' edited by Edward Webster and Karin Pampallis in: *The unresolved National Question: Left thought under apartheid* (Johannesburg: Wits University Press, 2017), 276.

apartheid regime through "negotiations" and "political settlement" as a vehicle to political power. Some key ANC members were coopted into the economic corridors of financial power in the private sector.

My research project provides an alternative epistemology to political theory using the healthcare system as a test case. My methodological perspective is Marxism. I keep this framework in mind as I present a historical account of the ideological debates in the ANC.

3.2 Historical development and the emerging debates

3.2.1 Brief background to healthcare and the apartheid system

I now consider how the ANC (and the SACP) responded to *(a)* the situation of apartheid generally and *(b)* the healthcare system in particular.

Article 25 of the UDHR on health states that, "Everyone has the right to a standard of living adequate for the health and well-being of himself and his family, including food, clothing, housing and medical care and necessary social services and the right to security."[2] This was not the case in South Africa during the 1940s. Black people in South Africa did not have rights, neither did they enjoy the benefits of Article 25 of the UDHR equally with whites. When the UDHR was adopted by the General Assembly of the United Nations on December 10, 1948 the South African context was characterized by racial segregation.[3] The divide between personal and public healthcare services in South Africa emerged within the context of a racialized healthcare system. This divide was later revised and transformed into a private and public system. Healthcare services in South Africa were inequitable.[4] They were offered along racial lines in urban and rural areas.[5] Personal healthcare services were curatively orientated

[2] Elvira Beracochea, Dabney P. Evans and Corey Weinstein, in Rights-based approaches to public health, edited by Elvira Beracochea, Corey Weinstein and Dabney P. Evans (New York: Springer, 2011), 7.

[3] In South Africa, in 1948, the National Party (NP) won elections and immediately began to roll out its program of apartheid. Effectively, when the UDHR was adopted the apartheid government ascended into power. Whist the UDHR (1948) was adopted against the background of World War II, in 1948, the right-wing National Party (NP) came to power and intensified racial segregation. Dr DF Malan had declared in his victory speech in 1948 that "South Africa [belonged to the Afrikaners] once more," and as soon as Malan assumed power, his racist Nationalist government rushed through a plethora of laws to promote its declared aim of officially applying strict and overt racial segregation. See: Elinor Sisulu, Walter and Albertina Sisulu: In our lifetime (Claremont: David Philips, 2010), 136.

[4] By this time in South Africa, the racist Nationalist Party was preparing for electoral victory against the South African Party. Prior to 1948, healthcare was understood not only as medical but also as having a social and political dimension.

[5] There was an initiative to transform the fragmented and inequitable nature of the healthcare system in 1942 (by the South African Party). Initially the conceptualization of the National Health Service (NHS) in South Africa was a result of the poor

and were mostly delivered in racially segregated hospitals. The National Party (NP) ascended into power and introduced the policy of apartheid in 1948. Black people did not have the right to a standard of living adequate for their health and well-being, they were to live within the context of the policy of apartheid. From 1948 onward in South Africa, the state policy of apartheid was consolidated, and a racially segregated and discriminatory hospi-centric healthcare service was preserved. Zweigenthal, London and Pick, maintain that,

> Fragmentation of a hospi-centric health service into 14 health departments resulted in massive duplication of service delivery, waste and inequity. There were marked differences in disease prevalence and mortality between races, with [Africans] faring the worst and [Europeans] the best. These outcomes reflected differences in living conditions, work, nutrition and access to services.[6]

Duplication of services was based on a racially divided healthcare system. In such a segregated healthcare system the European (white) settler minority experienced the best healthcare outcomes by comparison to the African majority. The result was high mortality rates amongst African people. South Africa was a case of the superior and inferior, the haves and the have-nots where whites have been deliberately made superior, therefore the "haves" and blacks deliberately made inferior, therefore the "have-nots."[7] Healthcare for South Africa's white minority was offered in a well-developed, richly resourced, complex network of urban public hospitals or within private facilities that were designed for whites only.

In the 1950s, the Group Areas Act (1950) was introduced by the apartheid regime. This legislation resulted in forced removals of black people from their homes and made way for the creation of segregated townships – as transit labour concentration camps. According to Mandela, Dr Malan "had introduced the Group Areas Act – which he described as 'the very

"white problem." Therefore, the discussion of the NHS focused on servicing whites only. The idea was based on ensuring that a mechanism was created for poor whites to access quality healthcare services.

[6] Zweigenthal, London, Pick, 'The contribution of specialist training programmes to the development of a public health workforce in South Africa,' 49.

[7] Steve Biko, *I write what I like: A selection of writings* (Johannesburg: Picador Africa, 2009), 54. Biko was a medical student. During his time, the healthcare system under apartheid was dysfunctional. The apartheid system had a massive impact on the healthcare economy. A major role was played by universities in perpetuating a systematized racial discrimination. There were discriminatory teaching practices at Medical Schools. Black students that were studying medicine were at a clear disadvantage. A segregated medical school was established for black students in Durban. Lectures were racially segregated. African students were to study in separate rooms from European students. African medical students were excluded from examination of European bodies at the segregated medical schools.

essence of apartheid' – requiring separate urban Areas for each racial group."[8] The rights of black people to "housing and medical care;" "necessary social services" and the "right to security" were undermined by the apartheid government. Such rights were secured for whites only.[9] Whites secured structural racial segregation by legislation.[10] Very few white South Africans could admit that their relatively high standard of healthcare and healthy living was purchased at the cost of the impoverishment and oppression of black people.[11]

3.3 Colonialism of a Special Type (CST) thesis and the two-stage theory of establishing a post-apartheid state

The South African Communist Party (SACP), unlike the African National Congress (ANC), had never aspired to be an African nationalist mass organization. It regarded itself as a vanguard of the revolutionary struggle in South Africa. It guided the ANC ideologically. A working relationship between the ANC and the SACP led to the formation of Umkhonto we Sizwe (MK) in 1961. Hence, both the ANC and the SACP held national conferences in 1962. The SACP held its congress in secret inside South Africa.[12] It is in 1962 that the SACP congress adopted

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[8] Nelson Mandela, Long walk to freedom: The autobiography of Nelson Mandela (London: Abacus, 2010), 130.

[9] The racist NP established economic policies to aid the development of Afrikaner capital and they built an apartheid state upon a racist capitalist accumulation growth path. The NP's ascendance to power resulted in the emigration of many European healthcare professionals. This marked the end of social medicine in South Africa. The majority of doctors that emigrated were European (English-speaking) urban-dwellers with a strong presence within the Department of Public Health (e.g. Sidney Kark, George Gale, former mission doctor and Secretary of Health from 1946, and Harry Gear, an epidemiologist. Virginia Zweigenthal, Leslie London, William Pick, 'The contribution of specialist training programmes to the development of a public health workforce in South Africa,' in *South African Health Review 2016* (Durban: Health Systems Trust, 2016), 48.

[10] According to Sisulu, "the policy of 'total apartheid as the ultimate goal of a natural process of separate development' meant that blacks would not be included in the whites-only welfare state." [See Sisulu, *Walter and Albertina Sisulu: In our lifetime*, 136.] To this, Suzman asserts, was added Verwoerd's "ruthless implementation of forced removals – one of the most appalling aspects of apartheid. It involved the forcible uprooting and 'resettlement' of black communities into Native Reserves or Bantustans. The policy aimed inter alia at eliminating the so called 'Black spots.'" See: Suzman, *In no uncertain terms: Memoirs*, 66.

[11] Ramphele, *Laying ghosts to rest: Dilemmas of the transformation in South Africa*, 77. Ramphele was a medical student and a contemporary of Biko at the time. The quality of education for Africans was low. African students were not allowed to study with Europeans; and African medical students were not permitted to observe or treat European patients (and vice versa). This produced asymmetrical medical skillsets and unequal medical expertise. A Europeans only ward, with European only patients, and Europeans only healthcare professionals, was like a private ward. Racism and segregation became the foundation for the private healthcare system.

[12] Stephen Ellis and Tsepo Sechaba, *Comrades against apartheid: the ANC and the South African Communist Party in exile* (London: James Currey, 1992), 36.

a new political programme called the *Road to South African Freedom*.[13] This political programme characterised the South African situation as a Colonialism of a Special Type (CST) and declared that the first aim of the struggle was a National Democratic Revolution (NDR).[14] The significance of this was that South Africa had become a colony of a special type (rather than of Holland, Britain, France, Portugal, Germany or Belgium). The SACP reaffirmed its belief that African nationalism can be a progressive force only when it is under the SACP's leadership [reiterating its strategy of seeking to work with the ANC as a broad front in the attainment of a national democratic revolution (NDR) in South Africa as the necessary first stage]. The first stage (national democracy and the downfall of the apartheid state) when achieved would lead to the eventual introduction of socialism (a second stage of the NDR). The SACP incorporated this view into a coherent political manifesto which was to remain the ANC's guide for the next 27 years (1962 –1989). According to Harmel,

> The 1962 Programme places at the forefront the 'immediate and foremost task' of the Party to 'work for a united front of national liberation…for a national democratic revolution to destroy White domination;' a revolution whose 'main content will be the national liberation of the African people" but which, "carried to its fulfilment" will at the same time put an end to every sort of race discrimination and privilege…restore the land and wealth to the people and guarantee democracy, freedom and equality of rights to all.[15]

The task of the liberation movement was to destroy European domination, racial discrimination, and European privilege in South Africa and restore the land and wealth to the African people. According to Ellis and Sechaba, "The [SACP's] persistent identification of the South African condition as being basically a colonial one, albeit of a special type not found elsewhere, had important implications in Marxist theory and therefore in determining the

[13] Ellis and Sechaba, *Comrades against apartheid: the ANC and the South African Communist Party in exile*, 37. The SACP Central Committee was able to meet in very small numbers of people meeting in private houses. In this manner the SACP succeeded in holding its underground congress in Johannesburg (November 1962, almost a decade later after its relaunch in 1953). The chairperson of the congress was J.B. Marks. The congress elected a new Central Committee which included ANC members: J.B. Marks, Duma Nokwe, Moses Kotane (SACP General Secretary), Govan Mbeki, Bartholomew Hlapane and Walter Sisulu.

[14] Ellis and Sechaba, *Comrades against apartheid: the ANC and the South African Communist Party in exile*, 37.

[15] Michael Harmel, in an article entitled, 'The Communist Party of South Africa,' edited by Alex Laguma (Ed.) in *A Collection of writings on South African racism by South Africans* (New York: International Publishers, 1971), 222.

strategy to be adopted by the [SACP]."[16] Harmel further affirms that, "The destruction of colonialism and the winning of national freedom [became] the essential condition and the key for future advance to the supreme aim of the Communist Party; the establishment of a socialist South Africa, laying the foundation of a classless, communist society."[17]

The issue in the African National Congress (ANC) has always been whether white monopoly capitalism was to be nationalized in a liberated South Africa. Thus, Oliver Reginald (O.R.) Tambo (ANC-SACP alliance figurehead and president of the ANC) equated the struggle for liberation with the struggle of the proletariat. As a result, he devoted his time and attention to the mobilization and organization of the proletariat.[18] However, Turok asserts that his personal interactions with Tambo bear out that he wanted no part in a debate about a socialist outcome in the struggle for national liberation in South Africa. Tambo insisted on remaining within the terrain of African nationalist ideology, and it seemed that Thabo Mbeki concurred.[19]

3.4 Adoption of the ANC Strategy and Tactics document

The ANC in 1969 called for a consultative conference (held in Morogoro, Tanzania, 25 April 1969) which was attended by delegates from the ANC, SACP, and Umkhonto we Sizwe (MK). It is this conference that confirmed O.R. Tambo as Acting President-General of the ANC (though Tambo was confirmed to be the ANC president in 1977). The conference was chaired by J.B. Marks [ANC and SACP veteran].[20] By 1969, Joe Slovo had established himself as MK's leading strategist and was respected by all MK militants. Slovo (and Joe Matthews) authored the ANC "Strategy and Tactics" document which sparked a debate at the 1969 ANC Morogoro conference and was duly adopted as the ANC's political programme. It was the first

[16] Ellis and Sechaba, *Comrades against apartheid: the ANC and the South African Communist Party in exile,* 37.

[17] Michael Harmel, in an article entitled, 'The Communist Party of South Africa,' edited by Alex Laguma (Ed.) in *A Collection of writings on South African racism by South Africans* (New York: International Publishers, 1971), 222.

[18] Sandi Baai, *OR Tambo: teacher, lawyer and freedom fighter,* (London: Memory Is Our Heritage, 2006), 197.

[19] Ben Turok, *From the Freedom Charter to Polokwane: the evolution of ANC economic policy* (Cape Town: New Agenda, 2008), *28.*

[20] Ellis and Sechaba, *Comrades against apartheid: the ANC and the South African Communist Party in exile* (p.37) further maintain that J.B. Marks had left South Africa with Slovo in 1963, studied in Moscow and was elected to the SACP Politburo, became SACP chairperson in 1969 (same year that he was chairing the ANC conference). The conference voted Duma Nokwe to be Secretary-General with Alfred Nzo. Moses Kotane (a communist) held the position of Treasurer General until 1973 (and was replaced by Thomas Nkobi, a non-communist). Moses Mabhida (a communist) took over from Joe Matthews as Secretary of the Revolutionary Council (RC). Cassius Make (communist) became Deputy Secretary and a dominant figure of the RC. Mabhida was joined by Slovo (Strategist), Yusuf Dadoo (Deputy Chairman) and Reg September. Mabhida became SACP General Secretary from 1978 till 1986.

time that the ANC had a written programme other than the Freedom Charter. Adoption of the "Strategy and Tactics" document by the ANC set the ANC on a course that was chartered by the SACP. The ANC enforced non-racialism. Adopting a strategy which was identical to the SACP fundamentally changed the ANC. The "Strategy and Tactics" document stated that, "national liberation is the chief content of the struggle;" and "[the] main content of the present stage of the South African revolution is the national liberation of the largest and most oppressed group – the African people."[21] According to Turok,

> In a thinly-veiled disguise of the South African Communist Party's (SACP) *two-stage theory* of revolutionary struggle in South Africa (later modified) and its conceptualisation of South Africa as representing a "colonialism of a special type," [CST] the document spoke of the focus of the present stage [first stage] of the struggle being "national liberation of the largest and most oppressed group – the African people…the national character of the struggle must therefore dominate our approach.[22]

The "Strategy and Tactics" document noted that liberation would be meaningless without the

[21] "Strategy and Tactics;" Statement adopted by the ANC at the Morogoro Conference, April-May 1969, in *From protest to challenge: a documentary history of African politics in South Africa, 1882 – 1990,* Vol.5: Nadir and Resurgence, 1964 – 1979 edited by Thomas G. Karis and Gail M. Gerhart (Pretoria: Unisa Press, 1997), 389. The Alma Ata declaration took place in September 1978. The UDHR was read by the liberation movement as a document that catalogued the rights of the human person. By the time of Alma Ata, the apartheid system in South Africa was institutionalized. During apartheid, to be human meant to be white. Africans in South Africa were considered non-whites and sub-human, therefore belonged to a third-class of non-citizens of South Africa. Whites on the other hand, were considered human and first-class citizens of South Africa. Thus, whiteness was linked to citizenship and was both a race and a class. More than being sub-human, to be African and black meant to be a *kaffir*, therefore not deserving of any rights, let alone human rights. Africans in the main, blacks in particular – the coloureds, and the Indians, did not have the rights to equality with whites. Though the coloureds and the Indians were granted second class citizenship, the Africans were considered a third class. Race was interiorised into class. On behalf of the ANC, one year earlier, Alfred Nzo, challenged proclamations in the Health Act No. 63 of 1977. Nzo released a statement that, [The ANC unapologetically denounces] this Act as having absolutely nothing to do with the comprehensive and adequate delivery of healthcare, [which] must invariably include promotional, preventive, curative and rehabilitative activities. Apartheid is a flagrant violation of the fundamental rights of man, one of which is the right to health…The health services for the blacks in South Africa are grossly inadequate and those that are provided show no concern for the emotional and psychological suffering of the [Africans]. For reference see: Zweigenthal, London, Pick, 'The contribution of specialist training programmes to the development of a public health workforce in South Africa,' 49. Nzo was elected ANC Secretary General at the Morogoro conference. Nzo became part of the ANC delegation that participated in talks with PW De Klerk after the unbanning of the ANC. Nzo was succeeded as Secretary General of the ANC by Cyril Ramaphosa. In 1994, Nzo was appointed to become the first Minister of Foreign Affairs in a democratic South Africa.

[22] Turok, *From the Freedom Charter to Polokwane: the evolution of ANC economic policy,* 24.

return of the wealth of the land to the people as a whole. It stated that, "It is therefore a fundamental feature of our strategy that victory must embrace more than formal democracy."[23] By the 1970s, the South African racist regime had consolidated the policy of apartheid.[24] Apartheid was "a flagrant violation of the fundamental rights of [persons]" and a crime against humanity. The ANC was waging a liberation struggle against the apartheid regime.[25] At the time, the health services for black people in South Africa were grossly inadequate. The National Party (NP) government was maintaining its grip on state power.[26] In the late 1970s and towards the 1980s, the ideology of "neoliberalism" and the economic concepts of "monetarism," "deregulation" and "privatisation" creeped into South Africa.[27] There was both

[23] ANC Strategy and Tactics document quoted by Turok.

[24] Apartheid was characterized by trauma, structural violence, segregation, and repression. Political exclusion, economic marginalization, social separation, and racial restriction policies structured South African society. There was a systematic development of segregated towns and cities. This apartheid-based structuring influenced the organisation of social and economic life and access to basic resources for healthcare, and healthcare services.

[25] In the 1970s, the political situation in the country became explosive. The apartheid government introduced a new Health Act No. 63 of 1977. The effect was that hospitals, clinics, and emergency centers including pre-hospital (ambulance) services were allocated exclusively to specific racial groups. Where hospitals served more than one group, separate wards were allocated to different racial groups. There was intense political opposition to apartheid; the African National Congress (ANC) exerted pressure on the apartheid government.

[26] In 1979, Margaret Thatcher was elected in the United Kingdom, and then Ronald Regan was elected US President in 1980. According to Lister, "The economics of monetarism and the politics of deregulation and privatisation, which these key figures advocated, foreshadowed a revitalisation of the brutal ideology elaborated by Friedrich von Hayek and Milton Friedman, which was soon dubbed 'neoliberalism'… This powerful political and ideological shift resulted in a 'Washington Consensus' in which the leading global financial institutions, the Washington-based International Monetary Fund (IMF) and the World Bank, more openly embraced the political and ideological agenda of the US Administration." See John Lister, *Health Policy reform: Global health versus private profit* (Oxford: Libri Publishing, 2013), 4. The Alma Ata declaration (September 1978) took place in this apartheid context. The objective of the Alma Ata Declaration was ensuring "Health for All." This ideal was not to be realised in South Africa as segregation policies of the NP-led apartheid regime undermined the objectives of the Alma Ata Declaration. During this time, inequities in healthcare resourcing were unambiguous. Healthcare was politicized. There was a tenfold difference in per capita funding between ethnic homelands and provincial healthcare systems. Comprehensive healthcare-based initiatives were developed by political activists that included health workers and doctors which were based on a commitment to social and economic development and community accountability (for example, the establishment of community-based clinics – *Zanempilo* and *Isolempilo* – by students who were members of the Black Consciousness Movement). This was a case of social ownership (socialization) of healthcare facilities which were being formed outside the privatized (private ownership) or public sector (state ownership). There was a politicization of healthcare. Where hospitals served more than one racial group, separate wards were allocated specifically for different racial groups. Healthcare facilities for the white minority had superior technology. Sanitary conditions for whites were better than those offered to the African majority in particular. Healthcare supplies for whites were incomparable to blacks. This included the number of patients per healthcare worker.

[27] The Geneva-based WHO, with its Assembly of member states, was marginalised. But in Canada, against the grain of capitalist countries moving towards austerity, health reform had begun in the mid-1970s. As a result, in 1984, the Canadian

a racially discriminatory logic and logistic in the South African healthcare economy at the time. There was also a systematic allegiance of European health professionals to apartheid ideology. Entrances to healthcare facilities were separate, as much as there were separate wards for blacks and whites. The NP began to adopt a neoliberal ideology and strategy. This led to the concentration of economic power within a handful of English and Afrikaner-led conglomerates.[28] This marked the starting point of private healthcare capital in South Africa. Increasingly, the private healthcare system drew resources away from the public sector. The apartheid government spent 65% of all healthcare expenditure in South Africa to only 17% of the population.[29]

Structural and racialized inequalities in the apartheid healthcare system, that have their roots in colonialism, persisted in South Africa. South Africa had become a highly industrialized country and the oppressed people generally constituted the proletariat. Like most capitalist countries, South Africa embraced both racism and neoliberalism as a governing ideology. The proletariat constituted the most powerful element of the liberation struggle. Communists were able to push their own socialist line through the ANC's governing body.[30] Turok holds that,

> [By 1985] non-racialism was reinforced by the election of non-Africans into the ANC NEC in the form of Mac Maharaj, Aziz Pahad, Reg September, James Stuart (aka Hermanus Loots) and Joe Slovo. The NEC was also given the power to co-opt

government completed the legislative framework for its Medicare system. Lister affirms that, "[The Canadian Medicare system] broke definitively from the previous US-style system based on private insurance and instead established a tax-funded 'single payer' system, giving universal cover: healthcare was to be provided by [independent] but non-profit, providers. Profit and private medicine were squeezed out of the Canadian system and the rapid year-by-year increases in spending which Canada had until then shared in common with its US neighbour, were brought under control." See: Lister, *Health Policy reform: Global health versus private profit*, 4.

[28] In the late 1980s, though healthcare services were racially fragmented, 40% of doctors worked in the private sector; this number increased to over 60% by 1990. From 1984 onwards there was a divergence between increasing healthcare costs in the US and the controlled share of GDP allocated to healthcare spending in Canada. According to Beracochea, Evans and Weinstein, "there is evidence that citizens of more affluent countries, such as the United States, do not enjoy better health outcomes than other countries. In a rights-based public health system, health would not be something only the rich can afford and in which charity is used to meet the health needs of poor, minority, or marginalised groups." See: Beracochea, Evans and Weinstein, in *Rights-based approaches to public health*, 12.

[29] Eagar, Cooke, Levin, and Wolmarans, 'Developing an approach to accounting for need in resource allocation between urban and rural district hospitals in South Africa,' in *South African Health Review 2014/15*, 102.

[30] Umkhonto we Sizwe (MK, armed wing of the ANC-SACP alliance) was led by Wilton Mkwayi. When Mkwayi was banished to Robben Island, the leadership of MK was passed to Joe Modise (commander of MK, 1964 – 1991. Contender for the post was Ambrose Makiwane (cousin of influential ANC member and communist Tennyson Makiwane). The second and last conference, the national consultative conference of the ANC's exile era, was held in Kwabe (Zambia, 1985).

> an additional five members, one of whom turned out to be Ronnie Kasrils. The [Kwabe] conference also agreed that its next gathering would be in South Africa.[31]

Non-racial solidarity had to be displayed. Furthermore, the interests of the white section of the population were to be protected. The notion of a mixed economy and the constitutional protection of private property was discussed in the ANC (in the 1980s). A mixed economy was to involve the co-existence of the "private sector" and a state controlled "public sector." This was a departure from communist ideology. But Tambo was not a communist ideologue and he was aware of the possibilities of negotiations with the apartheid regime. Therefore, Tambo appointed Pallo Jordan to draft a document (released in 1988) outlining the ANC's negotiating position. The following objectives were set out in the document:

> The entire economy must serve the interests and well-being of all sections of the population; the state shall have the right to define and limit the rights and obligations attaching to the ownership and use of productive capacity…the economy shall be a mixed one…property for personal use and consumption shall be constitutionally protected.[32]

According to Turok, with regards to issues such as "nationalization" or "public ownership" the document was vague. Turok maintains that regarding the "private sector" the document stated that, "[the private sector] shall be obliged to co-operate with the state in realizing the objectives of the Freedom Charter in promoting social well-being" (with regards to land it talked only of land reform).[33] A lack of clarity in methodology shows itself.[34]

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[31] Turok, *From the Freedom Charter to Polokwane: the evolution of ANC economic policy,* 30. Umkhonto we Sizwe (MK, armed wing of the ANC-SACP alliance) was led by Wilton Mkwayi. When Mkwayi was banished to Robben Island, the leadership of MK was passed to Joe Modise (commander of MK, 1964 – 1991, but Modise was not a communist). Contender for the post was Ambrose Makiwane (cousin of influential ANC member and communist Tennyson Makiwane). The second and last conference, the national consultative conference of the ANC's exile era, was held in Kwabe (Zambia, 1985).

[32] Turok, *From the Freedom Charter to Polokwane: the evolution of ANC economic policy,* 31. The title of the document is Constitutional guidelines for a democratic South Africa.

[33] Turok, *From the Freedom Charter to Polokwane: the evolution of ANC economic policy,* 31.

[34] In the late 1980s, in South Africa, though healthcare services were racially fragmented, 40% of doctors worked in the private sector (this number increased to over 60% by 1990). There was an adoption of the UN Convention on the Rights of the Child in 1989 to which a commitment was made to children as subjects and bearers of rights involving many corresponding duties on the part of government, schools, parents and the community (protection against violence, and exploitation, for example, or access to education and health services). See: Walter, Nowak, Sommer, Sax, Huber-Grabenwarter, *Human rights manual: Guidelines for implementing a human rights-based approach in ADC, 8.*

3.5 Intellectual origins of the two-stage theory

Now let me lay out the foundations of the *two-stage theory* which came from the SACP particularly. The origins of the *two-stage theory* in the ANC-SACP alliance lies with a handful of ANC members in the SACP who met in secret in Johannesburg (in 1962) to adopt a programme referred to as the *Road to South African Freedom*. But the true origins of the *two-stage theory* lay in the SACP's ideology of Marxism. The main theorists that influenced the SACP were Karl Marx, Frederick Engels and Vladimir Lenin. Engels states that,

> The proletariat seizes State power, and then transforms the means of production into State property. But in doing this, it puts an end to itself as proletariat, it puts an end to all class differences and class antagonisms, it puts an end also to the State as the State. Former society, moving in class antagonisms, had need of the State, that is, an organisation of the exploiting class at each period for the maintenance of its external conditions of production; therefore, in particular, for the forcible holding down of the exploited class in the conditions of oppression.[35]

South African society moved dialectically in race and class antagonisms. This was acknowledged by the ANC. Hence, the initial objective of the ANC was the seizure of power from a white minority and racist regime. The apartheid colonial state was an organisation of the exploiting class for the forcible holding down of the exploited class in the conditions of oppression for its conditions of production. The transformation of the means of production into state property was influenced by the SACP. The objective of putting an end to proletarianism was never the agenda of the ANC. It is the SACP that cast a vision of putting an end to all class differences and class antagonisms in South Africa; thereby casting a vision of a classless society. This vision influenced the ANC due to some members of the SACP being also members of the ANC, thereby holding dual membership.

Historically the ANC's strategy was to harness every conceivable instrument of struggle into a multi-pronged offensive which would draw the broadest front of opposition to the apartheid regime into active struggle.[36] In these terms the ANC always posed its objective as the seizure of power.[37] The transformation of the means of production into state property was always a

[35] Frederick Engels cited in Emile Burns, *The Marxist reader: the most significant and enduring works of Marxism* (New York: Crown Publishers, 1982), 577. Cited by Lenin in the State and Revolution.

[36] Pallo Jordan, *Letters to my comrades: Interventions and excursions* (Cape Town: Jacana, 2017), 242.

[37] Jordan, *Letters to my comrades: Interventions and excursions*, 242.

continuing discussion within the ANC, but the ANC did not resolve on this stance. The *two-stage theory* held that after the seizure of power (first stage) by the ANC, there was to be a seizure of the means of production by the ANC-led state (second stage). The doctrine of nationalization (conceptualized as a transformation of the private means of production into state property) comes from the *two-stage theory*. The second stage of the theory was understood to mean socialism.

In a Lecture (24 August 1969) Jack Simons taught within the ANC that, "Socialism contained a rejection of capitalism and raised a vision of a new type of society where the means of production would become public property under the control of the working [class]."[38] Such a transformation (a bringing into legal public ownership) of the privately owned means of production into state property is interpreted to mean "socialism." Engels goes on to say that, "the seizure of the means of production in the name of society – is at the same time its last independent act as a State;" and that "The State is not 'abolished,' it *withers away*."[39] Socialism would be the last independent act of an ANC-led state. Then the ANC-led state would "wither away;" a negation that is characterised by a socialization of the means of production (a form of social ownership).

Lenin, in interpreting Engels, suggests that, "Engels speaks here of the destruction of the bourgeois State by the proletarian revolution, while the words about its withering away refer to the remains of *proletarian* statehood *after* the Socialist revolution;"[40] thus the bourgeois State is put to an end "by the proletarian in the course of revolution. What withers away after the revolution is the Proletarian State."[41] According to Lenin, [1] Engels refers to "the period *after* the 'seizure of the means of production (by the State) in the name of society,' that is, *after* the Socialist revolution. [2] We all know that the political form of the 'State' at that time is complete democracy…when Engels speaks here of the State 'withering away,'…he speaks of democracy."[42] Jordan contends that in the South African context this meant that the struggle must result in the destruction of the apartheid colonial state.[43] This thesis, generally described as the theory of Colonialism of a Special Type (CST) thesis, has been the core of the debate

[38] Marion Sparg, Jenny Schreiner, and Gwen Ansell (Eds.), *Comrade Jack: the political lectures and diary of Jack Simons, Novo Catengue* (Johannesburg: African National Congress, 2001), 88.

[39] Burns, *The Marxist reader: the most significant and enduring works of Marxism,* 579.

[40] Burns, *The Marxist reader: the most significant and enduring works of Marxism,* 579.

[41] Burns, *The Marxist reader: the most significant and enduring works of Marxism,* 579.

[42] Burns, *The Marxist reader: the most significant and enduring works of Marxism,* 579

[43] Jordan, *Letters to my comrades: Interventions and excursions,* 238.

and the main element in ANC-led alliance's strategic approach to the liberation struggle for democracy.[44] The ANC was in favour of a democratic state. But the capitalist system was to be continued during a democracy. Wage labour was to remain the lot of the people. Lenin further affirms that,

> We are in favour of a democratic republic as the best form of the State for the proletariat under capitalism, but we have no right to forget that wage slavery is the lot of the people even in the most democratic bourgeois republic. Furthermore, every State is a "special repressive force" for the suppression of the oppressed class. Consequently, no State is either "free" or [a] "people's State." Marx and Engels explained this repeatedly.[45]

The apartheid state was a "special repressive force" for the suppression of the oppressed race and class. Neither was there freedom nor was it a people's state. The CST thesis held that the first stage of the revolution was the overthrow of the apartheid government and the destruction of the apartheid state. During colonialism and apartheid, the ANC and SACP held a common view that the contradiction between the colonized and super-exploited African majority and the racist oppressor state was the most visible and dominant contradiction in South Africa. The ANC and SACP further held that this contradiction cannot be solved by the colonial and apartheid state reforming itself out of existence. Moreover, the colonial and apartheid regimes were both racist and capitalist. Only the struggle to overthrow the colonial and apartheid system of white domination could lead to the resolution of this contradiction. But, the basic theoreticians of this view were Marx and Engels. Marx and Engels influenced the SACP theoreticians, chief being Slovo who was a member of both the ANC and SACP. Here is Engels' argument:

> [Force] is the midwife of every old society which is pregnant with the new; that it is the instrument with whose aid social movement forces its way through and shatters the dead, fossilised political forms… [Force] will perhaps be necessary for the overthrow of the economic system of exploitation – unfortunately.[46]

The first stage of the NDR was the overthrow of the apartheid racist regime and white minority rule (a first negation). The second stage of the NDR has to do with the destruction of the

[44] Jordan, *Letters to my comrades: Interventions and excursions,* 238.

[45] Lenin cited in Burns, *The Marxist reader: the most significant and enduring works of Marxism,* 579.

[46] Engels cited in Burns, *The Marxist reader: the most significant and enduring works of Marxism,* 582.

capitalist state (a second negation – the overthrow of the economic system of exploitation). Hence, the negation of the negation to introduce socialism in a democratic state. It has been the ANC's view that there is a dialectical relationship between the colonial and apartheid state and the colonised people in South Africa. Therefore, since the colonial and apartheid state and the colonised people cannot be spatially separated, there is no possibility of the two co-existing. The colonial and apartheid state had to be overthrown by the colonised people. The interregnum to suspend a violent revolution and the future peaceful development of socialism and a modification of the CST thesis led to the abandonment of the debate regarding a revolutionary overthrow of the apartheid regime and the second stage of the democratic revolution – the collapse of capitalist exploitation and the introduction of socialism. Thus, in the ANC-SACP's Marxist-Leninist analysis there was a connection between the development of socialism and democracy. According to Lenin,

> [The] teaching of Marx and Engels regarding the inevitability of a violent revolution refers to the bourgeois State. It cannot be replaced by the proletarian State (the dictatorship of the proletariat) through "withering away," … the replacement of the bourgeois by the proletarian State is impossible without a violent revolution. The abolition of the proletarian State…is only possible through "withering away."[47]

Implicit in the above quotation by Lenin is the *two-stage theory*. It informed political and military strategy in the ANC. In a two-stage theoretical sense, the abolition of the proletarian state is only possible through "withering away." Lenin pointed out that, "The proletariat must overthrow the bourgeoisie, conquer political power and establish its own revolutionary dictatorship."[48] In the South African context this meant that there was the inevitability of a revolutionary overthrow of the apartheid state (referred to as a bourgeois state) and replacing it with a democratic state (a proletarian state, a dictatorship of the proletariat). According to a Marxist theoretical tradition, this could not be done through the apartheid state "withering away." Marxism teaches that the replacement of the bourgeois state by the proletarian state is impossible without a violent revolution. In the ANC-led alliance there was a perceptible shift away from this strategic objective as a "*Path to Power*." There was a reconsideration and change of perspective regarding politico-military strategy amongst the ANC leadership. The

[47] Lenin cited in Burns, *The Marxist reader: the most significant and enduring works of Marxism,* 583.

[48] Burns, *The Marxist reader: the most significant and enduring works of Marxism,* 386.

evidence emerged later in the 1990s in an ANC document entitled: "*Strategic Perspective*."[49] This rethink rendered the *two-stage theory* dormant. The result was that capitalism and the capitalist exploitation of the African majority in a democratic South Africa was to be kept intact during an ANC-led regime. The capitalist crisis in the country was later not to change. However, the CST thesis, or *two-stage theory*, which had its basis in Marxism was abandoned. A democratic South Africa was to continue exhibiting the characteristics of colonialism of a special type (CST). Capitalism was not collapsed, and the future development of socialism was suspended. Lenin holds that,

> [Its] natural for Marx to raise the question of applying this theory both of the *coming* collapse of capitalism and to the *future* development of *future* Communism. On the basis of what data can the future development of future Communism be considered? On the basis of the fact that it *has its origin* in capitalism, that it develops historically from capitalism, that it is the result of the action of a social force to which capitalism *has given birth*.[50]

The theory of South African socialism develops historically from apartheid capitalism. It is a result of the action of the ANC-SACP alliance as a social force. The African poor, unemployed, and unemployable proletariat, and the working-class majority and precarious unemployed workers are the social force to which colonialism and apartheid capitalism has given birth. The objective of the apartheid regime was to retain white capitalist power and racist privilege for whites as a dominant racial group in terms of "ownership" and "control" of the strategic means of production in various sectors of the economy in post-apartheid contemporary society (when legal apartheid would have perished). Marx asserts that,

> "Contemporary society" is the capitalist society…[therefore] it is possible to speak of the "contemporary State" in contrast to the future, when its present root, bourgeois society, will have perished. Then the question arises: what transformation will the State undergo in a Communist society?... Between capitalist and Communist society…lies the period of the revolutionary transformation of the

[49] Also, the international convention on the protection of the rights of all migrant workers and members of their families was adopted in 1990.

[50] Lenin cited in Burns, *The Marxist reader: the most significant and enduring works of Marxism,* 585.

former into the latter. To this also corresponds a political transition period, in which the State can be no other than *the revolutionary dictatorship of the proletariat*.[51]

What transformation will the democratic state undergo in a socialist society (where capitalism is negated)? Between capitalist and communist society lies the period of the revolutionary transformation of capitalism. In the period of the revolutionary transformation of apartheid a general view within the ANC was that the CST thesis or *two-stage theory* suffered from a weakness in its reading of the South African social, political, and economic situation. Its analysis of the apartheid state was poor. The efficacy of the two-stage theory was to be questioned. The *two-stage theory* could not account for a path to power through negotiations. Its central thesis of seizure of power and basic ideological concepts were rendered irrelevant, and the CST thesis needed to be re-looked at. The Marxist question put somewhat differently: "the transition from capitalist society, [development] towards Communism, towards a Communist society [being] impossible without a "political transition period," and the State in this period [being] the revolutionary dictatorship of the proletariat, this question, remained unanswered.[52] There was a need for an alternative theory.

3.6 A debate amongst comrades as intellectuals in the ANC

In the debate and in seeking for an alternative theory, Jeremy Cronin (member of the SACP and the ANC) laid the foundation.[53] Cronin argued that there were three strategic perspectives: (1) *(a)* promoting a deal between the elites, and *(b)* a persuasion against mass action which was perceived to be antagonistic; (2) *(a)* negotiations as a viable route to power, and *(b)* agitation of the use of mass action to bring the apartheid regime to adhere to the terms of negotiations; (3) *(a)* insurrection *(b)* an overthrow of the apartheid regime.[54] After careful consideration, Cronin considered the second perspective as viable provided it combined a revolutionary perspective and practice with active engagement in the terrain of negotiations.

During the debate, Thabo Mbeki was the first to speak about a "sunset clause" and a "coalition cabinet" that included the apartheid National Party (NP) and the ANC.[55] Mbeki was more

[51] Marx cited in Burns, *The Marxist reader: the most significant and enduring works of Marxism*, 386.

[52] Burns, *The Marxist reader: the most significant and enduring works of Marxism*, 386.

[53] Johannes Mutshutshu Rantete, *The African National Congress (ANC) and the negotiated settlement in South Africa* (Hatfield: Van Schaik, 1998), 200.

[54] Rantete, *The African National Congress (ANC) and the negotiated settlement in South Africa*, 200.

[55] Rantete, *The African National Congress (ANC) and the negotiated settlement in South Africa*, 201.

moderate and diplomatic. In the debate about "nationalization" and "socialism" Mbeki outmaneuvered Slovo. This outmaneuvering is seen as the forerunner of present and future economic policy in the ANC. [56] But it is Slovo, seen as an ANC militant, that cemented the idea of a "sunset clause." Joe Slovo justified a "compromise" towards the apartheid government. He wrote a paper entitled: *Negotiations: What room for compromise?*[57] In the debate, Slovo argued that (1) the ANC and the apartheid government must negotiate because there was a stalemate in power relations; (2) the outcome of the negotiations would be less than the long-term liberation objective of the ANC; (3) a degree of compromise is inevitable. Slovo suggested a series of compromises that he argued were permissible: *(a)* the sunset-clause, *(b)* amnesty, and *(c)* security for apartheid incumbents. Non-compromise positions for Slovo were *(a)* an agreement on a minority veto, *(b)* compulsory power-sharing, and *(c)* binding the future democratic government to redress historical imbalances in the country. Slovo's suggestions were encapsulated in the ANC paper entitled: "*Strategic Perspective*."

Cronin backed Slovo and confronted Slovo's critics that they were not giving concrete details about attaining the objectives of the liberation struggle. Raymond Suttner entered the debate and supported Slovo's position. Suttner, during the debate, raised the option of making a deal directly with the affected white constituency.[58] Suttner supported (1) Slovo's power sharing deal; the thrust of his argument in the debate was (2) the need to engage the people in the negotiations process through *(a)* empowerment, not through *(b)* a revolutionary "bang."

Pallo Jordan (head of the ANC's department of information and publicity at the time) entered the debate. Jordan contended that the new thesis (in Slovo's argument) deviated from the strategic objectives of the ANC.[59] Jordan criticised the assumption for cooperation between the ANC and the apartheid government. Jordan argued that (1) the relationship between the ANC and the apartheid government was of opposition and was conflictual, (2) Slovo's perspective was ANC "Strategy and Tactics" revisionism – a revision of the ANC's conception of the struggle and that *(a)* negotiations were not a strategy nor a tactic but a key element of a political strategy, *(b)* negotiations had not been on the agenda, *(c)* non-violence was being

[56] Turok, *From the Freedom Charter to Polokwane: the evolution of ANC economic policy*, 28.

[57] Rantete, *The African National Congress (ANC) and the negotiated settlement in South Africa*, 201.

[58] Rantete, *The African National Congress (ANC) and the negotiated settlement in South Africa*, 201.

[59] Rantete, *The African National Congress (ANC) and the negotiated settlement in South Africa*, 201.

confused with negotiations justifying the elevation of negotiations into a strategy, *(d)* the option of compromise was cowardice (and that it was suicidal).

Cronin criticised Jordan. Cronin counter-argued that the deadlock was not a final showdown. Then Blade Nzimande (SACP in Natal at the time) entered the debate and criticised Cronin and rejected Slovo's arguments and proposals of power sharing.[60] Nzimande maintained that the ANC's stance should be an electoral defeat of the apartheid Nationalist Party (NP) and majority rule rendering the NP into a political opposition party in a democracy. Nzimande argued that (1) power sharing should be determined by the "balance of power" at the time of reaching settlement; (2) Slovo's proposed compromises were one sided and lacked foundation in the mass struggles of the people; (3) the compromises were seemingly to be made at a negotiating table focusing on what should be given to the other side and what should be retained; (4) Slovo was concerned with the freedom that should be given to the negotiators to negotiate and enter into agreements; and (5) there was a lack of concern about accountability to the ANC constituency and the role that it should play.

Harry Gwala also entered the debate. Gwala criticised Slovo's suggested political "compromise."[61] Gwala argued that (1) the political compromise lacked two things *(a)* mass action content and *(b)* class analysis; (2) Slovo addressed the fears of the racist minority regime; and (3) Slovo remained silent about the fears of the exploited oppressed majority. According to Gwala,

> It is not the good intentions of the negotiators and their ability to talk that will determine the fate of this country, important as this part of the struggle may be. But it will be the strength and ability of the contenders in the struggle that, in the final analysis, will determine the fate of this country. Any political expediency will lead to disaster.[62]

Having taken the debate into consideration, the ANC opted for the negotiations process, combined with mass action, international pressure, and the need to combat counter-revolutionary forces in the consequent bilateral meetings between itself and the apartheid government. The ANC chose to use phases in the period of transition to change the "balance of forces" to secure a democratic transformation through peaceful means. Slovo's proposals

[60] Rantete, *The African National Congress (ANC) and the negotiated settlement in South Africa,* 202.

[61] Rantete, *The African National Congress (ANC) and the negotiated settlement in South Africa,* 202.

[62] Rantete, *The African National Congress (ANC) and the negotiated settlement in South Africa,* 202.

for a "compromise" were accepted in the ANC; and the ANC proceeded with negotiations with the apartheid government as a vehicle to political power.[63]

3.7 Negotiations with the apartheid government

The ANC spearheaded negotiations with the apartheid regime. There was to be "cooperation" between the apartheid regime and the ANC-led alliance. The ANC accepted the need for negotiations and the formation of an Interim Government of National Unity (regardless of the verdict of elections) to facilitate the transfer of power. What then became of the conflictual relationship between the NP and the ANC and the diametrically opposed interests that the two represented? Instruments and forces of repression were carried along with the Government of National Unity (GNU). The ANC was catapulted from being an oppressed class to becoming a ruling elite. Lenin maintains that,

> We have seen that *The Communist Manifesto* simply places side by side the two ideas; the "transformation of the proletariat into the ruling class" and the "establishment of democracy." On the basis of all that has been said above, one can define more exactly how democracy changes in the transition from capitalism to [socialism].[64]

Consequently, democracy was established together with the co-option of the ANC into becoming a ruling class on the basis of the "balance of forces" – the objective basis for cooperation between the NP and the ANC alliance. With regards to democracy changing in the future and a transition from capitalism, there was no discussion of a transition from capitalism to socialism in the ANC. The ANC maintained that it was not a communist organisation. The ANC's ideological creed is, and has always been, African Nationalism. Articulating the ANC's concept of African Nationalism Mandela had stated that,

> It is not the concept of African Nationalism expressed in the cry, 'Drive the white man into the sea.' The African Nationalism for which the ANC stands [for] is the concept of freedom and fulfilment for the African people in their own land. The most important political document ever adopted by the ANC is the Freedom Charter. It is by no means a blue print for a socialist state…the ANC has never at any period of its history advocated a revolutionary change in the economic structure

[63] The armed struggle was abandoned. MK was rendered defunct. The ANC underground became redundant.

[64] Burns, *The Marxist reader: the most significant and enduring works of Marxism,* 587.

> of the country, nor has it, to the best of my recollection, ever condemned capitalist society.[65]

Mandela's stature overshadowed the ANC. In my view, the lack of condemnation of apartheid capitalism led to contradictory elements of cooperation with the apartheid regime. Also, the compromise led to a lack of meaningful economic change. This will have consequences for the healthcare system. The ANC was to lead South Africa to a democracy without consideration as to the material content of such a democracy for the majority, the dispossessed, and the poor. Democracy conceived this way, and lacking a material content for the voting masses, was to be bound by the narrow framework of capitalist exploitation, and consequently, always remains, in reality, a democracy for the minority, only for the possessing classes, only to protect the economic interests of the rich and wealthy.[66] Lenin holds that, in capitalist society, under the conditions most favourable to its development, we have more or less complete democracy in the democratic republic and that freedom in capitalist society always remains freedom for the oppressors.[67] The first objective of the oppressive apartheid regime became freedom from apartheid, and the apartheid regime's second objective was accommodation and sharing power with the ANC. As a result, De Klerk never surrendered power. The apartheid regime succeeded in arriving at De Klerk's formula of reformism (coupled with the systematic destabilization of the ANC) that made possible the co-existence of CST and democracy. This formula rendered the ANC too weak to resist such a compromise. The option of "compromise" permanently blocked meaningful economic change in the country. De Klerk's well formulated compromise option led the ANC to a dead end.

3.8 Political transition in the 1990s in relation to the healthcare economy

Now I consider the consequences of the compromise with regards to healthcare. My argument is that the private healthcare sector had roots in apartheid capitalism and in a racialized structure. The white minority-owned and capitalist-owned conglomerate private healthcare sector in South Africa has its foundations in apartheid capitalism and racism. Therefore, when the possibility of a non-racial society and majority rule had suddenly made the question of socialism particularly urgent, a strategy to shape a sociopolitical and economic transition

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[65] Nelson Mandela, *Long walk to freedom: The autobiography of Nelson Mandela* (Randburg: Macdonald Purnell, 1994), 352. Nelson Mandela (29 February 1964) when he told the court that he was not a communist.

[66] Burns, *The Marxist reader: the most significant and enduring works of Marxism,* 587.

[67] Burns, *The Marxist reader: the most significant and enduring works of Marxism,* 587.

towards a people's state (a democratic state) was required.[68] However, privatization became an affair of race relations in apartheid South Africa's established economic system. Southhall suggests that,

> From the mid-1980s [there was a] mobilization of popular forces into developing a counter revolutionary-strategy to shape a socio-economic transition that would parallel the political one and dissociate capitalist exploitation from racial oppression. Contacts, covert and otherwise, with senior members of the [African National Congress (ANC)] were seen as a way of securing a transition which would safeguard the essentials of the established economic system.[69]

Before Mandela was released from prison, and in view of the above quotation, in the 1990s there was a critical shortage of healthcare facilities for the poor African masses and the working-class of the population, alongside very sophisticated healthcare facilities for a white minority. Towards the period of the democratic transition, De Klerk's apartheid government adopted a policy of privatization and deregulation of healthcare services, thereby reducing spending on public healthcare services offered to the majority of the poor and working-class in the population. It was during this time, as the apartheid regime was unravelling, that the apartheid government introduced the policy of privatization of healthcare. Van Niekerk asserts that,

> The [National Party] promoted the introduction of market-based principles into public health and welfare services, as well as privatization of services. This thinking was reflected in the apartheid ministry of health's National Policy for Health Act 116 of 1990.[70]

As van Niekerk shows in the above quotation, it was the apartheid government that first introduced free market-based principles and the policy of privatization in the healthcare economy, not the ANC. Since then, the majority of white citizens, in the main, in South Africa have used private doctors, private clinics and private hospitals. In South Africa, race was interiorized into class. Research shows that 84 percent of the white citizens of South Africa still use private healthcare facilities. Choonara and Eyles confirm that, "the

[68] Burawoy, 'Painting socialism in Hungary,' *South African Labour Bulletin*, Vol. 14, No.6 (February 1990), 75.

[69] Roger Southhall, *Liberation movements in power: Party & state in southern Africa*, (Pietermaritzburg: University of KwaZulu-Natal Press, 2013), 78.

[70] Robert van Niekerk, 'ANC's rise and the decline to social democracy,' *South African Labour Bulletin*, Vol.38, No.1, (May/June 2015), 44.

private health sector covers only 16.2% of the population and enjoys the majority of financial and human resources in the country, while the public health sector serves the remaining 84% of the population."[71] Hence, each moment in South Africa contains other moments, aspects, or elements that have come from its past.

The phenomena in the healthcare service needs to be understood within this historical and political context. The healthcare service in South Africa was irrational, and it reflected a historical injustice. Apartheid policy of separate development and the promulgation of racist legislation sustained a two-tiered healthcare system. The mode of healthcare production was structured according to its race and class relations. Apartheid South Africa was both capitalist and racist and in race and class divided social formations state power is ultimately exercised by, and in the interests of, the race and class which owns the means of production.[72] At the centre of the apartheid government's policy of privatization was a belief in the free market. As a result, privatization and deregulation polarized the race relations between capital (white) and labour (black).

Though quality healthcare is both a service and an immaterial product it became necessary for the continuing existence of South African racist society.[73] Healthcare services offered to the African majority and black working-class deteriorated further. In addition, insufficient resources were channeled into the public healthcare sector. Free market policies hid the narrow profit interests of white capital. Privatization of healthcare services meant the financial exclusion from quality healthcare services for the working-class and poor majority. The concept of free healthcare for all was then introduced by the ANC during its campaign against apartheid towards a democratic transition.[74] At the time, the African majority of the population was susceptible to outbreaks and

[71] Shakira Choonara and John Eyles, 'National health Insurance: SA's most progressive health reform to date,' *South African Labour Bulletin*, Vol.40, No.1, (February/March 2016), 31.

[72] Joe Slovo, in a draft discussion paper entitled: 'Has socialism failed?' published in the *South African Labour Bulletin*, Vol. 14, No.6 (February 1990), 20.

[73] Ben Fine and Alfredo Saad-Filho, *Marx's Capital* (6th ed.) (London: Pluto Press, 2016), 14.

[74] See https://www.sahistory.org.za/sites/default/files/a_national_health_plan_for_south_africa.pdf. In the introduction of the concept of free healthcare for all. The 1994 ANC document entitled, *A National Health Plan for South Africa* reads, "Free health care will be provided in the public sector for children under six, pregnant and nursing mothers, the elderly, the disabled and certain categories of the chronically ill."

epidemics.[75]

Slovo, who was a senior member of the ANC and the General Secretary of the South African Communist Party (SACP) at the time, held a view that the basic socialist critique of capitalism is that a society cannot be democratic when it is ruled by profit and social inequality, and in which power over the most vital areas of life is outside public control.[76] Slovo maintained that, a people's state would be dedicated to the interests of the majority, who are working-class, and to moving towards a redistribution of wealth and to social advancement generally, rather than to private profit.[77] Yet, the ideology of the ANC elite was neoliberalism which promoted the sanctity of private property; imposed on this essentially Anglophile neoliberal core ideology was African nationalism.[78]

To illustrate: Mandela had published a statement a month before his release from prison which, citing the Freedom Charter, declared that "nationalization" was the policy of the ANC (a policy position which was a result of the influence of the SACP) and that any change of views in this regard was "inconceivable."[79] At the time, wealth was concentrated in the hands of a white minority. As I have shown earlier, a debate ensued amongst ANC intellectuals. Some within the ANC held the view that there were inherent contradictions that were contained within socialism. With Mandela's release and his statements on nationalization being a policy of the ANC and a strategy for wealth redistribution, a major debate raged. Slovo was of the view that redistribution of wealth does not mean that sectors of the economy would have to be nationalized. In a press interview, Evans had said to Slovo:

> You have been quoted as saying that the aim of [ANC] economic policy will be the redistribution of wealth, and that this does not mean that 'sectors of the economy would have to be nationalized'…and also that the important question is one of 'control, not ownership,' that sectors of the economy 'have got to be taken under control which [is] distinguish[ed] from state control.'[80]

In Evan's statement lies the tension that characterized the debate: the question of "ownership,"

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[75] Alec Erwin, in a paper delivered at a Paris Conference entitled: 'South Africa's post-apartheid economy: planning for prosperity' published in the *South African Labour Bulletin,* Vol. 14, No.6 (February 1990),40.

[76] Slovo, 'Has socialism failed?' 15.

[77] Gavin Evans, 'Interview with Joe Slovo,' *South African Labour Bulletin,* Vol.39, No.1, (February/March 2015), 56.

[78] Moeletsi Mbeki, *Architects of poverty: Why African capitalism needs changing*, (Johannesburg: Picador Africa, 2009), 58.

[79] Southhall, Liberation movements in power: Party & state in southern Africa, 78.

[80] Evans, 'Interview with Joe Slovo,' 56.

and "control" of strategic sectors of the economy by the democratic state. Slovo had moved away from the position of legal "ownership" of the means of production by the state in strategic sectors of the economy. He was managing the intellectual debate. There was one challenge within the ANC. The challenge was that within the liberation movement there was dual membership. This means that a person could be both a member of the ANC and the SACP at the same time. Therefore, members of the SACP could advance a socialist point of view, that of "nationalization," within the ANC. Others advanced an alternative view, that of "privatization," also within the ANC.

As I have also shown earlier, the ANC at the time was guided by a *two-stage theory*. The basic tenets of the theory held that the first stage of the revolution was national liberation. This meant that a struggle for national democracy had to be prioritized. After national democracy was achieved and consolidated then socialism could be ushered in during the second stage of the democratic transition. However, experience has shown that a capitalist logic of the South African economy has been managed by the ANC, and the question of socialism has been suspended. But, the formulation of the *two-stage theory* recognized that South Africa was both a racist and capitalist state. First the racial aspect of apartheid had to be defeated then the capitalist and exploitative aspect of apartheid could be dismantled at a much later stage – a second stage – of the national democratic revolution.

Thus, the theory of a two-stage revolution meant that the examination of a South African socialism could be postponed, due to inherent contradictions that were contained in Soviet socialism.[81] On this basis, towards the democratic transition, the ANC and its allies, the SACP and the Congress of South African Trade Unions (Cosatu) then developed a set of alternative policy proposals which were based on the Freedom Charter.[82] The ANC, on the 31 May 1992, published a document entitled, *Ready to Govern: policy guidelines for a democratic South Africa*. At the time, the Transkei, Bophuthatswana, Venda, and Ciskei (TBVC) Bantustans had their own separately developed healthcare systems. According to the ANC's analysis,

> The health service [was] controlled by a great many departments – one in each of the [Bantustans] and separate ones for general affairs and for each of the [Europeans], [Coloureds] and Indian[s]…It [was] impossible to effectively plan

[81] Burawoy, 'Painting socialism in Hungary,' 75.

[82] Van Niekerk, 'ANC's rise and the decline to social democracy,' 44.

and co-ordinate healthcare between these different ministries.[83]

The healthcare service was characterized by structural racial inequalities and separate development. There was arguably an inextricable link between apartheid, racial domination, and capitalism. However, many sectors were state-owned, though they were being prepared for privatization. This meant that envisioned after the transition from apartheid was a large private sector alongside the public sector. According to the ANC (1992), "the private sector [focused] its efforts on those who can pay, [emphasized] the treatment of disease, and so [neglected] the promotion of good health, the prevention of disease and the rehabilitation of the disabled."[84] Therefore, only a minority, with a particular class content, could afford to pay monthly medical aid premiums to purchase private healthcare services.

3.9 Private healthcare capital and the ANC's vision of free healthcare

Now I consider in detail the emerging ANC position on healthcare. As I have noted, it is important to take into consideration apartheid and the linkages between racialized structures and the private healthcare system.

The economic policies of Afrikaner racist capital and the apartheid state, along with the extreme concentration of economic power within a handful of Afrikaner-led conglomerates, was the starting point of private healthcare capital in South Africa.[85] Social relations of production within the private healthcare sector became specific to the apartheid mode of production and they reproduced themselves over time. The major weakness which emerged in the intellectual debate within the ANC was based on an unclear articulation of what the practice of socialism in South African society would entail if a distortion of socialism and a misapplication of communism was to be evaded.[86] The historical position of the ANC was that the provision of equitable healthcare should be guided by the Freedom Charter (1955); and that the principles which reflect an approach to healthcare be the ones adopted by the World Health Organisation (WHO) and the United Nations Children's Fund (in Alma-Ata, 1978) and that

[83] African National Congress (ANC), Ready to Govern: ANC policy guidelines for a democratic South Africa, as adopted at the National Conference retrieved from: http://www.anc.org.za/docs/pol/1992/readyto.html#H. Date of retrieval: 23 June 2017.

[84] ANC, Ready to Govern: ANC policy guidelines for a democratic South Africa. See: http://www.anc.org.za/docs/pol/1992/readyto.html#H.

[85] Alec Erwin, 'South Africa's post-apartheid economy, planning for prosperity,' *South African Labour Bulletin*, Vol. 14, No.6 (February 1990), 43.

[86] Slovo, 'Has socialism failed?' 15.

these principles should form part of the ANC's vision.[87] The Freedom Charter (clause 9), declares that, "A preventative health scheme shall be run by the state;" and also asserts (in clause 9) that, "Free medical care and hospitalization shall be provided for all" and that, "[the] aged, the orphans, the disabled, and the sick shall be cared for by the state" (line 7).[88] Privatization of healthcare by the apartheid regime was an action that was contrary to clause 9, line 5, of the Freedom Charter. Yet, equal access to free quality healthcare was seen by the liberation movement to be a moral and political imperative. To implement the Freedom Charter, and to provide "free medical care and hospitalization for all" became the duty and obligation of the ANC-led government. The Freedom Charter bound the ANC to the duty of providing free quality healthcare for all in South Africa. Therefore, the policy of "free quality healthcare for all" (which is inherent in the National Health Insurance (NHI) plan for the South African healthcare system) has its ideological origins, theoretical basis and its philosophical foundations in the Freedom Charter, not necessarily socialist ideology. Nonetheless, Mandela had, at a later stage, changed his initial stance that the the policy of the ANC was nationalization and that a change of view in this regard was inconceivable. Southhall points out that,

> By February 1992, [Mandela] declared that the inconceivable was necessary, having been persuaded by delegates from China and Vietnam at the World Economic Forum in Davos, Switzerland how they had come to accept the interdependence of national economies and consented to private enterprise after the collapse of the Soviet Union.[89]

This is a continuous story that has been told in Davos. Regarding Mandela's first trip to the Alpine Resort in January 1992, Davies says that, "It was perhaps the most fascinating of Davos gatherings ever up until that point. The domino collapse of the Eastern Bloc states had recently occurred and just a few weeks prior at Davos, the Soviet Union had ceased to exist. It was the end of an empire, the end of communism."[90] However, Burawoy held that it was necessary to return to the basics of Marx and Lenin's theory of a transition to socialism and to understand the dynamics of a race and class struggle.[91] Moreover, ex-communists in the ANC had decided

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[87] ANC, Ready to Govern: ANC policy guidelines for a democratic South Africa (online).

[88] A. Lerumo, *Fifty fighting years: The South African Communist Party 1921 – 1971* (London: Inkululeko Publications, 1987), 128.

[89] Southhall, *Liberation movements in power: Party & state in southern Africa*, 78.

[90] Martyn Davies 'Leveraging Davos network and global political economy,' *The Star* (Business Report, Wednesday, 24 January 2018), 18.

[91] Burawoy, 'Painting socialism in Hungary,' 76.

that advanced capitalism had more to offer than socialism.[92] Therefore, there was a retreat from advancing socialism and nationalization of the conglomerate private healthcare sector during the political transition in the 1990s.[93] Slovo argued that, "Socialism is a transition period, a moving from one economic reality to another. When power is taken the previous economic reality [does not] completely disappear. The new power can use many different mechanisms in order to begin the process of redistribution of wealth."[94] This was a clear case of ideological revisionism. Slovo further asserted that,

> We should try to refine our understanding of nationalization so that its purpose and its relationship to effective popular control is emphasized. And even in relation to the transfer of legal ownership, the question as to whether it is a complete take-over, whether compensation is or [is not] going to be given, will have to be determined by the reality of the correlation of forces.[95]

According to Davies, the reality of the correlation of forces was that, "external forces made the ANC's Freedom Charter-based statist and socialist policies immediately obsolete."[96] Regarding the Freedom Charter, Mandela argued that,

> The clause discussing the possible nationalization…was an action that needed to be taken if the economy was not to be solely owned and operated by white businessmen. The charter was in fact a revolutionary document precisely because the changes it envisioned could not be achieved without radically altering the economic and political structure of South Africa. It was not meant to

[92] Pallo Jordan, 'Crisis of conscience in the SACP,' *South African Labour Bulletin*, Vol.15, No.3, (September 1990), 66.

[93] In the 1990s, UN agencies, embraced HRBAs in their programmes. The collapse of the Soviet Union and the health reform program developed in the 1990s, led to the difficult challenges that characterized the healthcare system in Russia. Thus, the Russian healthcare system is outlier. Mikhail I. Davydov, and Oleg P. Shepin, in an article entitled: 'The Russian Healthcare System,' published by *Medical Solutions* in the Essay Series: Healthcare Systems – Russia (September 2010), in page 74, maintain that, "At the end of the 20th century, the collapse of the Soviet Union and ensuing radical changes in the country's social and economic policy engendered healthcare problems and systemic challenges, many of which are yet to be addressed." After the Russian political transition, the provision of healthcare services, to improve the population's health, became the responsibility of the state. However, there developed in Russia a private healthcare sector. Consequently, the cost of healthcare increased. Also. there developed alongside a mandatory healthcare insurance (MHI) program, a voluntary health insurance (VHI) program.

[94] Evans, 'Interview with Joe Slovo,' 57.

[95] Evans, 'Interview with Joe Slovo,' 57.

[96] Davies, 'Leveraging Davos network and global political economy,' 18.

be…socialist.[97]

The fact remains that the Freedom Charter was influenced by socialist ideologues within the ANC. Nevertheless, during the collapse of the Soviet Union a whole range of communist political parties had criticized the Soviet model of socialism. Yet, the future of South Africa lies in its own style and pattern for the socialist development of post-apartheid society, and its own model of social ownership of property.[98] Slovo maintained that, "nationalization is not a catch-all solution for the problem of social ownership."[99] Thus, when the ANC was the democratic government-in-waiting, there was a policy shift in political economic thinking. Southhall asserts that, "The shift in thinking about nationalization was just one outcome, albeit a key one, of the pressure of external forces." [100] Davies recalls that,

> When questioned about nationalization, Mandela spoke of the Freedom Charter and the socialist ideology of the ANC. After finishing, Li Peng – Premier of the People's Republic of China – turned to Mandela and said (something along the lines of) 'Don't do that Mandela. We tried it and it failed. You should privatize instead.' This was the premier of the world's largest communist state espousing market liberalism to the new leadership of South Africa. Such is the (often informal) power of Davos.[101]

Communist parties throughout the world had been thrown into theoretical disarray and confusion, including the SACP (which had been aligned with the Communist Party of the Soviet Union).[102] The working-class and progressive forces in each country were to develop their own strategic approach, their own national road to socialism.[103] Hence, Choonara and Eyles suggest that national healthcare system takes a socialist approach to universal healthcare: against the degradation of the ideals of communism.[104] The concern is how will a socialist and solidaristic initiative be implemented in South Africa's neoliberal environment?[105] According

[97] Mandela, *Long walk to freedom: The authorized biography of Nelson Mandela*, 206.

[98] Jordan, 'Crisis of conscience in the SACP,' 66.

[99] Evans, 'Interview with Joe Slovo,' 57.

[100] Southhall, *Liberation movements in power: Party & state in southern Africa*, 79.

[101] Davies 'Leveraging Davos network and global political economy,' 18.

[102] Burawoy, 'Painting socialism in Hungary,' 75.

[103] SACP, *South African road to socialism*, 5.

[104] Shakira Choonara and John Eyles, 'National health Insurance: SA's most progressive health reform to date,' *South African Labour Bulletin*, Vol.40, No.1, (February/March 2016), 31.

[105] Choonara and Eyles, 'National health Insurance: SA's most progressive health reform to date,' 31.

to Evans, Slovo maintained that, "There [was] little left of what we used to call a world socialist economic system. Socialism has, for the moment, proved incapable of competing with the world capitalist sector, for reasons [he] outlined in [a pamphlet entitled] 'Has Socialism Failed?'"[106] Generally South Africans with money had (and still have) no difficulty obtaining a level of healthcare rivaling that provided anywhere in the world. For the poor, the story is different.[107] Publicly subsidized health services were available on a fee-for-service basis.[108] Jordan (in response to 'Has Socialism Failed?') maintained that, Marxism aims to uncover the (complex) reality that lies hidden behind appearance.[109] Southhall asserts that Mandela had said (to his comrades) that,

> 'Chaps,'…'we either keep nationalization and get no investment, or we modify our attitude and get investment.' Not all the chaps came [around] to his new way of thinking, but those who were in charge of economic policy – if they had not done so already – did.[110]

The debate to nationalize the private healthcare sector was then unresolved. It was held up in the tension between the question of either "ownership" or "control" of the private healthcare sector. Thereafter, the ANC in the year 1992 proposed the creation of a comprehensive National Health Service (NHS) – that operates within a framework of a dual, two-tiered, healthcare system that is divided into a private and public healthcare sector. According to the ANC (1992),

> There will be a single governmental structure dealing with health for the whole country. It will coordinate all aspects of both public and private healthcare delivery. It will be accountable to the people of South Africa through democratic structures. All existing government departments of health including homeland, military and prison services, will be integrated into the [National Health Service (NHS)], and all racial, ethnic, tribal and gender discrimination will be eradicated from the service…The NHS will actively promote community participation in the planning,

[106] Evans, 'Interview with Joe Slovo,' 57.

[107] Oscar A. Barbarin and Linda M. Richter, *Mandela's children*, (London: Routledge, 2001), 52.

[108] Barbarin and Richter, *Mandela's children*, 52,

[109] Jordan, 'Crisis of conscience in the SACP,' 66.

[110] Southhall, *Liberation movements in power: Party & state in southern Africa*, 78. Citing Anthony Sampson, *Mandela: The authorized Biography* (Cape Town: Jonathan Ball, 1990), 434-35.

provision, control and monitoring of services.[111]

The ANC consequently committed to a mixed economic system (with both capitalist and socialist features). Von Holdt holds that, "A mixed economy is pluralistic, in the sense that it allows different classes to pursue their economic interests – workers, capitalists, petty bourgeoisie and the middle strata."[112] The ANC further held that, "the provision of healthcare by the private sector will continue to be acknowledged and regulated."[113] In this sense, the dual, separate, two-tiered system that has its origins in racism and segregation was maintained. A dual (separately developed) healthcare system was acknowledged by the ANC. Instead of developing one, transformed healthcare system, a dual and two-tiered racialized healthcare system was reinforced. Healthcare became a commodity to be traded in the free market system. In such system, the high standards of quality healthcare, especially for the white minority, were maintained. Yet, in the rural villages, townships, and the squatter settlements, where the poor and African working-class majority lived, healthcare services were of a poor quality and of a low standard, if not non-existent.

In February 1993, the ANC published a Bill of Rights, as a preliminary revised text, for a new South Africa.[114] In Article 11, subsection (8) on the Right to Health, the Bill of Rights states that, "A comprehensive national health service [NHS] shall be established linking health workers, community organisations, state institutions, private medical schemes and individual

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[111] ANC, Ready to Govern: ANC policy guidelines for a democratic South Africa (online).

[112] Karl Von Holdt, 'Class struggle and the mixed economy,' *South African Labour Bulletin*, Vol. 14, No.6 (February 1990), 48.

[113] ANC, Ready to Govern: ANC policy guidelines for a democratic South Africa (online). The ANC document further stated that, "Appropriate and efficient data collection will be an essential part of the NHS. It will allow for rational management and planning and also relevant research to address the most important problems facing the community. The private sector will also be required to collect and submit both financial and clinical data in order to facilitate planning at local, regional and national levels. The health service will be planned and regulated to ensure that resources are used in the best way possible to make essential healthcare available to all South Africans, giving priority to the most vulnerable groups. Health workers at all levels will promote general health and encourage healthy lifestyles. The NHS will seek to establish appropriate mechanisms that will lead to the integration of traditional and other complimentary healers into the NHS."

[114] The Declaration on the Right to Development was reaffirmed by the World Conference on Human Rights in Vienna in 1993 (immediately after the end of the Cold War). Thereafter, at the World Conference on Human Rights (Vienna, 1993) an agreement was reached on the principles of the universality, indivisibility, interdependence and equality of all human rights. This conference affirmed the conviction of the international community that the right of a people to self-determination as well as economic, social and cultural rights are just as important as civil and political rights. See: Broberga and Sano, 'Strengths and weaknesses in a human rights-based approach to international development – an analysis of a rights-based approach to development assistance based on practical experiences,' 666.

medical practitioners." The Bill of Rights reflected the dual and racialized two-tiered nature of the healthcare system, which was kept intact. It reinforced the dualism of the two-tiered (private/public) fragmented healthcare system which was accommodated during the democratic transition. Such a fragmented healthcare system was exploited by the white monopoly capitalist class to benefit the white-owned conglomerates in the private healthcare sector. Hence, prior to the 1994 democratic transition, according to the NHI White Paper, "South Africa had a fragmented health system designed along racial lines. One system was highly resourced and benefited the white minority. The other was systematically under-resourced and was for the black majority."[115]

In the year 1994, Cosatu proposed the Reconstruction and Development Programme (RDP, 1994) in order to advance working-class demands, and the aspirations of the African poor majority. Due to the policy of dual membership, since the launch of the RDP (1994), the SACP has chosen to campaign on the basis of single African National Congress (ANC) electoral lists.[116] Slovo held a view that,

> [The SACP's role was] a vital constituent of the liberation alliance headed by the ANC, and as an independent organisation pursuing the aspirations of the working class…The ANC will remain the overall head of the broad national liberation movement whose task in the immediate aftermath of victory will be to consolidate our liberation objectives. We need now to build an ANC of massive strength, and every [SACP] militant must help to make this a reality.[117]

The ANC campaigned using the RDP (1994) as their manifesto. The policy of ANC in the RDP could have affirmed the public healthcare sector and seek to improve it; and should have negated the conglomerate private healthcare sector and seek to nationalize it. However, Mandela argued that,

> The charter guaranteed that when freedom came, Africans would have the opportunity to own their own businesses in their own names, to own their own houses and property; in short, to prosper as capitalists and entrepreneurs. The charter does not speak about the eradication of classes and private property, or

[115] Department of Health, 'White Paper on National Health Insurance (NHI) for South Africa – Towards universal health care coverage,' 5.

[116] South African Communist Party (SACP), *South African road to socialism* (SACP: 13th Congress Political programme, 2012 – 2017), 7.

[117] Evans, 'Interview with Joe Slovo,' 56.

> public ownership of the means of production, or promulgate any of the tenets of scientific socialism.[118]

With reference to the intellectual debate as shown earlier, the view to advance privatization, capitalism, and private ownership of the means of production triumphed over the view to advance nationalization, socialism, and the public ownership of the means of production. Slovo had maintained that,

> Blacks [had] been prevented from participating in the private sector [and that] it was consistent with [the ANC's] broad social vision to demand the repeal of legislation and the creation of conditions in which, during the period when there will be a private sector, blacks are not disadvantaged. It does not follow from this that [the ANC] embarked on a deliberate policy to try to replace the white exploiters with black exploiters.[119]

Slovo further maintained that, "We must distinguish between a legal change of ownership from private hands to the state and the process of what [Marx and Lenin] called socialization."[120] Lenin states that, "The socialization of production cannot fail to lead to the transfer of the means of production."[121] Moreover, Slovo suggested that, "Nationalization in the sense of a simple change of ownership without taking steps to ensure democratic participation by the producers at all levels of economic life does not necessarily advance the socialist objective."[122]

In the prioritization of social democracy, as the first stage of national liberation, the apartheid opponent was defeated in 1994. Consequently, in April 1994, the ANC won the democratic elections. Effectively, the ANC was voted into power. Mandela became state president of a democratic South Africa. However, the democratic victory of the ANC did not necessarily mean that the white racist and capitalist class was suppressed in the establishment of a democratic state. After the 1994 democratic victory, a new class had emerged. Burawoy suggests that,

> This new class has been called the 'nomenclatura' or a 'bureaucratic caste' or 'teleological re-distributors.' It is placed in opposition to the class of direct

[118] Nelson Mandela, *Long walk to freedom: The authorized biography of Nelson Mandela* (London: Abacus, 1994), 206.

[119] Evans, 'Interview with Joe Slovo,' 56.

[120] Evans, 'Interview with Joe Slovo,' 57.

[121] Vladimir I. Lenin, *The teachings of Karl Marx*, Vol. 1 (New York: International Publishers, 1935), 29.

[122] Evans, 'Interview with Joe Slovo,' 57.

> producers. The two classes are antagonistic because the producers of surplus do not control how the surplus is appropriated, distributed or used by this new dominant class.[123]

The bureaucratic class became a class formation which had the capacity to command the labour of others and whose power was derived from its (bureaucratic) control over the means of production rather than the (social) ownership of the means of production. Jordan states that, "[This bureaucracy] behaves like a class in that it is able to reproduce itself, through easier access to better education; favoured treatment for its members and their families; and special status in all spheres of public life."[124] The base of the bureaucratic class in the democratic South Africa is the ANC. Slovo had said that,

> In the building of a mass-based ANC it is inevitable that some strata with their own agenda will flock into its ranks and will, consciously or otherwise seek to steer it away from its working-class bias. We should be ready for an inevitable sharpening of inter-class ideological contest [in the aftermath of victory].[125]

The new class of bureaucrats responsible for the smooth functioning of the state came into existence and acquired an identity and an interest apart from the rest of society.[126] Such a bureaucracy stood above the class of direct producers and consumed the surplus produced by the working-class.[127] As a result, the capitalist state was not destroyed by this new dominant class in their co-option by apartheid racist rulers. Instead, during the post-1994 period, there was an integration of South African capital markets into the world system which was a product of the overall process of capital globalization and of contested decisions about financial liberalization taken by the democratic government.[128] It is in 1994 that the Minister of Health appointed a Committee of Inquiry into a National Health Insurance (NHI) which made recommendations to phase out private healthcare funding within five to ten years.[129] It is in the same year that the RDP was published by the ANC.

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[123] Burawoy, 'Painting socialism in Hungary,' 75.

[124] Jordan, 'Crisis of conscience in the SACP,' 69.

[125] Evans, 'Interview with Joe Slovo,' 56.

[126] Jordan, 'Crisis of conscience in the SACP,' 70.

[127] Jordan, 'Crisis of conscience in the SACP,' 68.

[128] South African Communist Party (SACP), Special National Congress: 08 – 10 April 2005, Coastlands Hotel Durban, Vol. 2 (SACP: Congress Discussion Documents, 2005), 2.

[129] Cosatu National Health Committee 2015, 'Towards the National Health Insurance: Draft Cosatu booklet on affordable and accessible healthcare,' (Johannesburg: Cosatu, 2015), 7.

3.10 Conclusion

This chapter gave background to the ideological origins of privatization of healthcare in South Africa. Its central thesis is that the two-tiered healthcare system in South Africa has its origins in the political philosophy of apartheid and economic ideology of racism, segregation and discrimination, with deep roots in South Africa's history of colonialism, white domination, and capitalism. It showed that in the 1990s a debate raged within the African National Congress (ANC) regarding the strategic objective of the ANC. Its aim was to show that there was a tension that characterized the debate on the strategic objectives of the ANC and the question of "ownership" and/or "control" of strategic sectors of the economy. Key to the debate was the question of the *two-stage theory* of the National Democratic Revolution (NDR) referred to as the Colonialism of a Special Type (CST) thesis. I explained the meaning of the *two-stage theory* and its argument. However, I show that the CST thesis was abandoned. The ANC took the route of negotiations as a vehicle to political power. I briefly discussed the healthcare conditions of the majority during apartheid. I showed that towards the democratic transition in South Africa the apartheid government privatized the healthcare sector and introduced free market-based principles into the healthcare economy. But there was a racist basis to privatizing healthcare. The next chapter traces the historical evolution of the NHI policy within the policy shifts in the African National Congress (ANC). It affirms that there are two competing healthcare systems that survive the ANC policy shifts.

Chapter 4

Economic policy shifts within the ANC and evolution of NHI policy

4.1 Introduction

The previous chapter was largely a historical account of the ideological debates within the ANC and the SACP regarding the nature of the struggle and thinking on the healthcare system. It gave background to the historical and ideological origins of privatization of healthcare in South Africa. It showed that towards the democratic transition the apartheid government privatized the healthcare sector and introduced free market-based principles into the healthcare economy. Thus, the concept of the National Health Insurance (NHI) system can be traced back to the period in South Africa during the democratic transition.

This chapter traces the historical evolution of the NHI policy within the policy shifts in the African National Congress (ANC) in the democratic period. Keeping in mind the underlying philosophical basis where relevant, it affirms that there are two competing healthcare systems that survive ANC policy shifts. In the chapter, I locate the discourse on the NHI system in the historical policy shifts within the ANC. I show that two healthcare systems developed in opposition to one another, one private (to service the minority) and the other public (to service the majority). However, there were forces pushing the economy towards a more socialist system. Such forces were calling for an overhaul of the two-tiered system and for the NHI system to be phased in. Notably, the concept of the NHI system can be traced back to the democratic transition period during 1994. However, the concept of free healthcare for all in a *unified* healthcare system emerged during 1997.

4.2 National Health System (NHS) as a precursor to the NHI system

In this section, I present an overview of the development in ANC thinking about the healthcare system as a background for understanding the latest development, its relation to the public/private healthcare sectors and the tensions between them.

In the 1990s, South Africa had remained a capitalist society that became characterized by variants of capitalist class domination. After the 1994 democratic transition, there was a necessity for transformation in the healthcare economy. However, the free market was institutionalized. Neither was it a neutral structure of exchange. The healthcare economy

reflected the race and class relations that underpinned it. Moreover, once apartheid was removed a "pure" capitalism developed during the first stage of national democracy. Under capitalism, the products of labour generally take the form of commodities, and they are generally distributed by market exchanges.[1] Market freedom brought about an appropriation of the labour of one class by another. The transformation process of the healthcare system required reconstruction and redress of an apartheid heritage. This required a review of the legislation and an integration of world standards into post-apartheid norms and practices. However, two healthcare systems further developed in opposition to one another, one private (to service mainly whites, privileged, and well resourced) and the other public (to service mainly blacks, underprivileged, and poorly resourced). On one hand, there were forces pushing the economy towards a more socialist system, with more public ownership and more detailed planning; on the other hand there were powerful forces pushing the economy towards weakening the role of the state and freeing markets to give greater scope to private capital.[2] Von Holdt states that there was to be room for market forces and a private sector, but the fundamental perspective of working-class organisations would be to work for conditions that make possible the steady advance towards a democratic socialist society.[3]

At this point, the African National Congress (ANC) adopted the Reconstruction and Development Programme (RDP, 1994) as its manifesto for the 1994 democratic elections. The RDP is a policy document that was drafted within Cosatu and published by the ANC. It was used as a guiding document for the transformation process during the democratic transition. In the case of healthcare, Article 1.2.3 of the RDP (1994) states that segregation in healthcare "left deep scars of inequality and economic inefficiency."[4] The RDP (1994) under Article 2.12.5 entitled: National Health System (NHS), further asserts that, "One of the first priorities is to draw all the different role players and services into the NHS."[5] The capitalist class intended to use the policy of the NHS to support the further development of capitalism in the healthcare economy. Hence, the RDP (Article 2.12.5) states that the NHS, "must include both public and private providers of goods and services and must be organised at national, provincial, district

[1] Ben Fine and Alfredo Saad-Filho, *Marx's Capital* (6th ed.) (London: Pluto Press, 2016), 17.

[2] Karl Von Holdt, 'Class struggle and the mixed economy,' *South African Labour Bulletin*, Vol. 14, No.6 (February 1990), 48.

[3] Von Holdt, 'Class struggle and the mixed economy,' 46.

[4] African National Congress (ANC), *The Reconstruction and Development Programme (RDP): A Policy Framework,* (Johannesburg: Umanyano Publications, 1994), 2.

[5] *Reconstruction and Development Programme (RDP): A Policy Framework,* 43.

and community levels" (Article 2.12.5.1).[6] The role of the private healthcare sector within the South African healthcare system has been acknowledged by government since 1994. Yet, the majority of the population in South Africa attended a public clinic or used the services of a doctor in public service. Inequalities have adversely affected the healthcare sector, and this has adversely affected the working-class in general and the poor in particular. The challenges of inequalities within the healthcare system have been a problem since before 1994. However, during 1994, the RDP (Article 2.1.2) had aimed at setting South Africa firmly on the road to "improving our health services and making them accessible to all."[7] Mainly, the RDP aimed at cheapening and facilitating the provision as rapidly as possible of a universal, affordable, and sustainable access to healthcare for all.[8]

The policy of the ANC, as articulated in the RDP (1994), could have affirmed the public healthcare sector and seek to improve it; and could have negated the conglomerate private healthcare sector and seek to nationalize it. However, in the conceptualization of the NHS in South Africa, from the onset, the ANC involved both public and private healthcare providers (in a two-tiered healthcare system). Therefore, in the RDP (Article 2.12.5.1) exists two contradictory possibilities. There remained a contradictory relationship between the public and private healthcare sector. Such a relationship ceased to be a static one, it became a complex racialized dynamic. The existence of the two sectors in the same system and their contradictory relationship resulted in the public healthcare sector providing poor services (in principle raising the question of the collapse of a free quality public healthcare system) and the private healthcare sector offering a perceived higher quality service (in principle raising the question

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[6] *Reconstruction and Development Programme (RDP): A Policy Framework*, 43. The concept of the NHS in South Africa aimed at publicly providing and publicly financing healthcare. This means that there would be access to *free*, quality, healthcare facilities for the entire population (citizens and non-citizens). Such a system was to exist independently of the private medical insurance industry. Yet, there would remain a private healthcare sector, even though it would exist within a country that has a National Health System (NHS). Any patient that seeks for a private healthcare service would need to cover the cost themselves. However, "state patients" would receive public healthcare *for free* (the conceptual category of *healthcare provision*). It is also important to reiterate that in the context of a mixed economy in South Africa those patients seeking private healthcare must cover their own private healthcare costs where private healthcare is *for sale* (the conceptual category of *healthcare purchasing*). What is notable is that, in the public healthcare system, within the context of the NHS, healthcare is decommodified (it is a use-value). It is provided for free (not exchanged for money). I hold a position that healthcare needs to be *decommodified.* Healthcare is a use-value. As a use-value, the population does not pay for accessing healthcare services at the point of use, they have financial risk protection.

[7] *Reconstruction and Development Programme (RDP),* Article 2.1.2, 14: Taken from a formulation of the problem statement in the RDP.

[8] *Reconstruction and Development Programme (RDP),* Article 2.8.4, 34.

of the affirmation and expansion of the private healthcare system). In this context, the ANC was committed to restructuring the healthcare system. As a result, the ANC on 30 May 1994 released a policy document entitled: *A National Health Plan for South Africa*.[9] The ANC's vision entailed creating a single, integrated, and legislated National Health System (NHS). Hence, *A National Health Plan for South Africa* held that,

> A single comprehensive, equitable and integrated National Health System (NHS) will be created and legislated for. A single governmental structure will coordinate all aspects of both public and private healthcare delivery and all existing departments will be integrated.[10]

The policy of the ANC, as seen in the above quotation, kept intact the two-tiered system of the public and private healthcare system. Thus, it recognized that the South African government through its apartheid policies created racialized institutions and facilities. These institutions and facilities were built and managed during apartheid with the specific aim of sustaining racial segregation and discrimination in healthcare.[11] Such a racially segregated system was doctor-centric and focused on curative care, instead of preventative care. It sustained racial discrimination in the healthcare sector. However, private healthcare continued to be treated as a commodity and not a use-value with the ability to satisfy human needs. Private healthcare continued to be sold and produced *for sale* and was sold to those who could afford it. In addition, *A National Health Plan for South Africa* further states that,

> The net result has been a system which is highly fragmented, biased towards curative care and the private sector, inefficient and inequitable. Team work has not been emphasized, and the doctor has played a dominant role within the hierarchy. There has been little or no emphasis on health and its achievement and

[9] African National Congress (ANC), *A National Health Plan for South Africa* (May 1994). Taken from the ANC's website at http://www.anc.org.za/content/national-health-plan-south-africa. Date retrieved: 24 June 2017. In its foreword the document states that, "The first draft of this plan was prepared by a team consisting of members of the ANC Health Department and consultants appointed by the World Health Organization and UNICEF. It was based on documents prepared by the ANC Health Policy Commissions and others in the democratic movement." Furthermore, "[the] second draft was prepared by a similar team, following a national workshop called specifically to discuss and modify the first draft. The second draft was released for public debate and discussions in January 1994.

[10] African National Congress (ANC), *A National Health Plan for South Africa* (May 1994). See: http://www.anc.org.za/content/national-health-plan-south-africa. Date retrieved: 24 June 2017.

[11] ANC, *A National Health Plan for South Africa* (May 1994). See: http://www.anc.org.za/content/national-health-plan-south-africa. Date retrieved: 24 June 2017.

> maintenance, but there has been great emphasis on medical care. The challenge facing South Africans [was] to design a comprehensive [healthcare system].[12]

The fragmented curative-care-focused healthcare system, within which the doctor has played a dominant role, became hospi-centric, and placed an emphasis on medical specialists. Such an inequitable (racially segregated) healthcare system became inefficient and expensive. Access to this system was largely though private clinics and private hospital facilities which became expensive and offered services to a minority that could afford it. Such a system, though it had very little or no emphasis on health, expanded its own sphere of activity and increased its power in the healthcare economy. Private healthcare became an expensive commodity that was produced for South Africa's capitalist society. In such a racialized capitalist society, the public healthcare sector offered public healthcare services through public hospitals and public clinics. Such facilities were of poor quality and were designed for the poor majority and those with working-class backgrounds. The power of the public healthcare sector became limited. In addition, racialized inequalities (including income inequalities and gender inequalities) remained intact within an unequal, hierarchical system.

Being a transitional state, the democratic state accommodated a broad range of race and class interests. The national democratic state which was based on a mixed economy became biased towards the private sector. A mixed economy opened the way for a race and class struggle between different race and class forces. To one sector, the private healthcare sector, healthcare was treated as a *commodity* to be sold and traded in the free market system at an exorbitant price. To the other sector, the public healthcare sector, healthcare was treated as a *use value* (to be offered *for free* to a certain extent to the poor masses) financed by the ANC-led democratic government. As a use-value, public healthcare products were not treated as normal commodities in the free market system, and healthcare services were not commercialized in public healthcare facilities, though they were made to have exchange-value.

During this period (1994), there was a crisis in the conglomerate private healthcare sector as a sector which was heavily depended on the medical aid system. When the Government of National Unity (GNU) was formed there emerged in the ANC a discussion regarding the National Health Insurance (NHI) as a predictable contingency. This means that there was a shift from the concept of the NHS as understood in the RDP (1994) to the concept of the NHI.

[12] ANC, *A National Health Plan for South Africa* (May 1994). See: http://www.anc.org.za/content/national-health-plan-south-africa. Date retrieved: 24 June 2017.

This shift was created because of a growing private healthcare sector in a two-tiered system and the perception that the private healthcare sector offered better quality care. Therefore, a financing mechanism was required to enable access into the private healthcare sector for the majority of the population. The question that was raised was: is the option of the NHI feasible? Therefore, the introduction of the concept of the NHI in ANC political discussions and ANC policy discourse can be traced back to the period in South Africa during the democratic transition in 1994, when the ANC made a recommendation to the GNU to consider a compulsory NHI system. Hence, in *A National Health Plan for South Africa* it states that,

> It is recommended that a Commission of Inquiry be appointed by the Government of National Unity [GNU] as a matter of urgency, to examine the current crisis in the medical aid sector and to consider alternatives such as a compulsory National Health Insurance (NHI) system.[13]

A commission was to be set up to investigate the appropriateness and economic feasibility of a National Health Insurance (NHI) system within the South African healthcare context; and undertake detailed planning for implementation of an NHI system, if there was sufficient consensus on this option.[14] There was a necessity to improve access to the private healthcare sector, especially for the African majority as users; and to simultaneously improve the quality of the public healthcare sector.[15] There remained a view that the private healthcare sector plays an important role in the delivery of healthcare services.

4.3 A commitment to the free market, privatization, and neoliberalism

During Thabo Mbeki's term as deputy president (1994-1999), the RDP was revised. The South African government's focus was on economic growth (instead of development and redistribution). Therefore, the government prepared for a new macroeconomic policy strategy. By 1996, the condition of the public healthcare system worsened. There was a structural problem in the healthcare system as a legacy of apartheid. The challenge required a systemic restructuring process. The Growth, Employment, and Redistribution (GEAR, 1996) strategy

[13] ANC, *A National Health Plan for South Africa* (May 1994). See: http://www.anc.org.za/content/national-health-plan-south-africa. Date retrieved: 24 June 2017.

[14] ANC, *A National Health Plan for South Africa* (May 1994). See: http://www.anc.org.za/content/national-health-plan-south-africa. Date retrieved: 24 June 2017.

[15] According to the National Health Act 61 of 2003, a user is a person receiving treatment or care in a health establishment, whether public or private. The term "user" also includes a child's parent or guardian (or any other person authorised to act on the child's behalf) if the person accessing treatment or care is a child.

was introduced as a macroeconomic policy to the benefit of the private healthcare sector, especially the financial services sector component (for example, healthcare insurance services). As a result, in the year 1996, there was a shift from the RDP (1994) to GEAR (1996). In Mbeki's opening address of the National Assembly in Parliament, in the year 1999 when he became South African president, regarding the RDP (1994) and GEAR (1996) Mbeki said that,

> [The RDP and GEAR] were implemented by our first democratic government to achieve socioeconomic transformation and macroeconomic stability. The structural changes entailed within these processes were also to take place within the context of our economy becoming more competitive as it integrated itself within the global economy. The RDP and GEAR will remain the basic policy objective of the new government to achieve sustainable growth, development and improved standards of living.[16]

GEAR (1996) was ideologically committed to the free market and neoliberalism. Privatisation and neoliberalism stood at the centre of GEAR (1996) as the government's economic policy.[17] Interestingly, Mbeki distorted Marx and Lenin to justify GEAR, in that he held that capitalism had to reach its highest stage of accumulation before a socialist economy could be introduced.[18] But, as a macroeconomic policy, GEAR (1996) was based on the accumulation of capital at the expense of the poor and the working-class. Due to GEAR being a neoliberal macroeconomic policy, public funding for healthcare declined – leading to serious under-staffing of the public health sector, with many important staff positions remaining vacant. The shortage of staff had not only affected the quality of the actual services but had meant that administration and upkeep of health facilities had not been maintained. GEAR (1996) emphasized *free* and universal access to comprehensive primary healthcare. It asserts in Article 6.2 that, "The systematic restructuring of health services, with a strong emphasis on universal and free access to comprehensive primary care, represents a clear commitment to improving the health conditions of the poor…towards overcoming the inadequacies of hospitals and clinics in rural areas and townships."[19] GEAR (1996) further asserts that most of the policy

[16] A speech by Thabo Mbeki, *Africa define yourself*, 'Our season of hope,' an address at the opening of parliament, National Assembly (Cape Town: Tafelberg, 25 June 1999), 35.

[17] Ebrahim Harvey, 'Labour's defining moment: the anti-privatisation strike,' *South African Labour Bulletin*, Vol.25, No.5, (October 2001), 41.

[18] Mark Gevisser, *Thabo Mbeki: The dream deferred* (Johannesburg: Jonathan Ball Publishers, 2007), 672.

[19] *Growth Employment and Redistribution (Gear) Strategy: A macroeconomic strategy*, (Republic of South Africa: Department of Finance, 1996), 15.

frameworks and institutional systems were in place to ensure universal access to primary healthcare.[20] The plan for universal health coverage (UHC) has never explicitly changed. When GEAR (1996) was introduced the two-tiered public and private healthcare system was entrenched. Moreover, the emphasis on private healthcare implicit in GEAR (1996) totally removed the vision of a national health plan for universal healthcare coverage from practical reality.

After 1996, a discussion in the ANC regarding a free and unified healthcare system started to appear. At its 50th National Conference (22 December 1997) the ANC published its Strategy and Tactics document – as amended by the conference. In the document the ANC states that, "To continually improve the health of the nation, primary healthcare [remained] the main plank of the country's health programmes. Critical to this is the intensification of the clinic-building programme and the construction of hospitals where they are needed most."[21] A discussion of the concept of a unified healthcare system or a unified national health service emerged during 1997. As a result, the concept of *free* healthcare in a unified healthcare system was featured in the 52nd National Conference of the ANC, in its adopted Strategy and Tactics document. The ANC held that,

> A national democratic society should use the redistributive mechanism of the fiscus to provide a safety net for the poor. As such, built into its social policy should be a comprehensive social security system which includes various elements of the social wage such as social grants, free basic services, free education, free healthcare, subsidized public transport and basic accommodation.[22]

The objective of the ANC-led government was to offer free healthcare for the poor and the working-class. In 1997, the South African government published a White Paper to present principles of a *unified* healthcare system. The White Paper (1997) for the transformation of the health system in South Africa declares that, "The object of the White Paper is to present to the people of South Africa a set of policy objectives and principles upon which the Unified

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[20] *Growth Employment and Redistribution (Gear) Strategy: A macroeconomic strategy*, 21.

[21] African National Congress (ANC), 'Strategy and Tactics' document, available at: www.anc.org.za/content/anc-strategy-and-tactics-adopted-50th-national-conference. Date retrieved: 24 June 2017. Also, in 1997, as a result of the UN reforms, interest increased across the UN in integrating human rights into programming. See: *UNAIDS Global Reference Group on HIV/AIDS and Human Rights*, 'Issue paper: What constitutes a rights-based approach? Definitions, methods, and practices,' 1.

[22] ANC, 'Strategy and Tactics' document. See: http://www.anc.org.za/content/52nd-national-conference-adopted-strategy-and-tactics-anc. Date retrieved: 24 June 2017.

National Health System [NHS] of South Africa will be based."[23] From 1997, the ANC's objective was to transform the dual (two-tiered) healthcare system and to create a single (or unified) healthcare system. Therefore, the concept of a unified healthcare system in South Africa is not new (or particular to the NHI policy and legislation, 2011 – 2018). The challenge for the ANC-led government was that the two-tiered fragmented healthcare system did not have the capabilities to deliver free quality healthcare to all citizens, especially the majority of the population. Dr Nkosazana Dlamini Zuma, who was the Minister of Health at the time, through the White Paper (1997) declared that,

> We have set ourselves the task of developing a unified health system capable of delivering quality healthcare to all our citizens efficiently and in a caring environment. The strategic approach guiding us in this endeavour is that of [comprehensive primary healthcare]. We believe this accords with the health objectives spelt out in the Reconstruction and Development Programme [RDP, 1994], the vehicle for socioeconomic transformation in our country.[24]

However, there remained a disparity in the resource allocation for the public and private sector. It was not possible to implement a *unified* National Health Service (NHS) program to provide *free* healthcare and hospitalization for all through a single healthcare system to South African citizens, funded by the South African government. From 1998 to 2001 the healthcare system continued to be characterized by a two-tiered system. In 2001, Cosatu filed a Section 77 demanding that government halt all privatization.[25] The trade union movement was part of the democratic state and it had a real stake in it.[26] The anti-privatization strike at the end of August 2001 brought to a head a simmering struggle against privatization by Cosatu.[27] Privatization was associated with massive job losses at provincial, national, and local level. The ANC, SACP, and Cosatu were interdependent forces of the liberation alliance.[28] The SACP and Cosatu opposed privatization. Cosatu's reasons for opposing privatization was that most

[23] Department of Health, 'White Paper for the transformation of the health system in South Africa,' (Notice 667 of 1997).

[24] Department of Health, 'White Paper for the transformation of the health system in South Africa,' (Department of Health: Republic of South Africa, Notice 667 of 1997).

[25] Congress of South African Trade Unions (Cosatu), 'The realities of privatisation,' *South African Labour Bulletin*, Vol.26, No.5, (October 2002), 29.

[26] Gavin Evans, 'Interview with Joe Slovo,' *South African Labour Bulletin*, Vol. 39, No.1, (February/March 2015), 56.

[27] Ebrahim Harvey, 'Labour's defining moment: the anti-privatisation strike,' *South African Labour Bulletin*, Vol. 25, No. 5, (April 2001), 41.

[28] Evans, 'Interview with Joe Slovo,' 56.

working-class households earned inadequate salaries, therefore could not afford basic goods and services from the private sector.

There was an unequal resource allocation for the two-tiered healthcare system. The challenge facing the South African healthcare system was the disparity in the resources available to the public and private sector relative to the population each sector serves. The private healthcare sector continued to benefit from the national health budget on an unequal ratio. Yet, the private healthcare sector was servicing 16 percent of the population. A larger percentage of whites (80.8%) used private healthcare services.[29] The relationship between the two sectors (private and public) ensured that the two sectors could not work together to deliver free healthcare services using combined resources. The government emphasized that it cannot tackle this challenge alone and it required that both sectors work hand in hand to use combined resources to meet the healthcare needs of all South Africans in a more equitable and efficient manner.[30] This, however, seems to me practically impossible. The goal of racialized capital within the healthcare system was that all health services be privately provided. This goal contrasted the goals and the objectives of the ANC with regards to the healthcare economy. By the year 2005 there was a policy conundrum within the ANC.[31] The policy of the RDP (1994) was abandoned by Mbeki's regime, and the introduction of GEAR (1996) had led to further privatization, rising

[29] Johan Biermann, 'South Africa's Health Care under Threat,' International Policy Network, Health Policy Unit (Johannesburg: Free Market Foundation, 2006), 4. Bierman counter argues that, "The envisaged unified national health system ignores the failures of the country's existing government health sector and the evidence from other countries that socialised health systems are [1] inefficient, [2] expensive, [3] lack sophisticated medical equipment, [4] have long waiting lists for medical procedures and appointments with specialists, do not provide equal access to and equal treatment for all citizens, [5] provide lower quality healthcare than private providers, control costs by rationing care and medical technology, and [6] fall far short of attaining their lofty ideals."

[30] Bierman further suggests that, "There are two very different approaches to the problem of ensuring that people have adequate access to health care. One approach is for the government to attempt to gradually nationalise all health-care services, ultimately ending with fully taxpayer-funded state-owned health services. The other approach is to establish a healthcare environment in which private healthcare [financing] and provision can grow rapidly, serving an increasing percentage of the population to the point where all health services are privately provided" (Biermann, 'South Africa's Health Care under Threat,' 4.).

[31] This conundrum caused problems. Also, it is in the UN, in 2003, that several UN bodies convened a workshop for the production of a statement entitled: *The Human Rights-Based Approach to Development Cooperation – Towards a Common Understanding Among the United Nations Agencies.* The statement identifies and explains six human rights principles to which special weight must be given; namely: *(i)* Universality and inalienability; *(ii)* Indivisibility; *(iii)* Inter-dependence and inter-relatedness; *(iv)* Accountability and the rule of law; *(v)* Participation and inclusion; and *(vi)* Equality and non-discrimination. Broberga and Sano, 'Strengths and weaknesses in a human rights-based approach to international development – an analysis of a rights-based approach to development assistance based on practical experiences,' 666.

unemployment, and the expansion of the financial services sector.[32]

There was another economic policy which was referred to as the Accelerated Growth Initiative South Africa (AsgiSA, 2004) which was introduced by the government. During this time, private healthcare prices increased. The ownership of the conglomerate private means of healthcare production in South Africa were in the hands of the white minority which generated wealth from the conglomerate private healthcare sector. AsgiSA (2004) maintained that, "At 28,2%, health is the second largest component of provincial budgets. Provinces collectively overspent their overall health budgets."[33] However, healthcare workers that were trained by the state were recruited to work for the private healthcare sector. Many doctors were in private practice but also working a few hours in state hospitals. There were difficulties in retaining the skills and expertise of healthcare workers in the public healthcare system. AsgiSA (2004) affirms that, "[There were] difficulties in retaining the skills of a range of health professionals...[including] funding of the public health system, as well as the need for closer co-operation and partnerships between the public and private healthcare systems."[34] The policy of AsgiSA failed to accelerate shared growth; the public healthcare economy lacked the requisite skills and expertise for sustainability. As a result, the government introduced the Joint Initiative on Priority Skills Acquisition (JIPSA), as part of AsgiSA (2004). As stated in AsgiSA (2004),

> The public health system faces skills constraints in a range of fields, and at different levels of the system. [JIPSA] has identified planning and management capacity as a priority skills requirement, both to ensure more effective and efficient management of the system, and to strengthen the capacity and the mechanisms to ensure that the skills that are available, are optimally supported and utilised.[35]

JIPSA (2005) also failed in its initiative for skills requisition. In the year 2007, the government shifted to the Industrial Policy Action Plan (IPAP). The IPAP is an industrial policy that discusses various sectors of the economy and shows the various opportunities that are available

[32] In 2005 Mbeki fired Zuma as deputy president and appointed Phumzile Malambo-Ngcuka to be deputy president. Then there was an economic policy shift towards the Accelerated Growth Initiative South Africa (AsgiSA, 2004). Mbeki introduced AsgiSA (2004). AsgiSA (2004) was adopted in 2005. Having undermined the alliance between the African poor majority and the working-class, especially in the healthcare economy, Mbeki lost support of the majority of the members of the ANC. In the year 2008, Mbeki was recalled by the ANC as state president and he resigned from the state presidency.

[33] *Accelerated Growth Initiative South Africa – AsgiSA* (Presidency: Republic of South Africa, 2004), 14.

[34] *Accelerated Growth Initiative South Africa – AsgiSA,* 48.

[35] *Accelerated Growth Initiative South Africa – AsgiSA,* 48.

in the economy, and which sectors the government has committed its investment. The healthcare industry is one industry that the government identified as having a positive return on investment. Yet, to achieve the objectives of the IPAP, the people in the country required skills and expertise, but there was a healthcare skills deficit. The IPAP points out that the National Health Insurance (NHI) programme aims to create a single healthcare system over 12 years (2012 to 2025).[36] Unfortunately, the IPAP does not address the human resource requirement for the healthcare economy. During the 2009 Red October campaign by the SACP, the NHI campaign was launched at OR Tambo Hall at Khayelitsha. Blade Nzimande (SACP Secretary General) addressed the meeting. Regarding the NHI, Nzimande stressed that,

> [Those] who are financially better off will have to contribute [to the NHI] more than those who are poor, but that ultimately all people stand to benefit. Powerful business interests are opposed to the NHI because it will cut into their profits…[the] private sector is predicting doom with the implementation of the NHI.[37]

According to Magaxa, Manamela (who was the Young Communist League [YCL] National Secretary at the time) maintained that, "The NHI will mean better facilities, more hospitals, and more clinics. It will mean more accessible and more affordable health services, especially for people in the rural areas and the townships. It will mean quality healthcare for all."[38] Nzimande further pointed out that,

> We have previously said much about the centrality of the establishment of a [national health insurance (NHI) scheme] for the provision of accessible, affordable and quality [healthcare] for all South Africans. The fundamental principle of an NHI is that of ensuring that every South African, rich or poor, black or white, employed or unemployed, is covered by this scheme. The aim of the scheme is to ensure that no South African must be expected to make upfront

[36] Kgalema Motlante became (interim) state president in 2008-2009. There was a policy discussion that an industrial policy would have to be developed and published by the government in various iterations. The department of trade and industry (dti) was to drive the Industrial Policy Action Plan. The NHI is cited in the IPAP 2014/15 – 2016/17, 93. Seloana asserts that, "The truth is that those who are opposing this noble direction are those who have unlimited financial resources, especially the private hospital sector players, who want to continue making more profits through their exorbitant service costs, while the health of poorest of the poor in bad state." See Tshepo Seloana, *The New Age*, 'Anti-forces against NHI condemned,' Monday, 22 January 2018, 16.

[37] Magaxa, 'Forward to NHI – Forward to health care for all!'*Umsebenzi: Voice of the South African Communist Party* (Johannesburg: SACP, October 2009), 2.

[38] Magaxa, 'Forward to NHI – Forward to health care for all!' 2.

payment for health services, whether in the public or private [healthcare] sector.[39]

Nzimande acknowledged that both sectors will continue to co-exist within the context of the NHI system. The ANC held an elective conference where Jacob Zuma was elected to be the president of the ANC. Thereafter, Zuma became state president. Choonara and Eyles assert that, "It was only at the ANC's elective conference in 2009 that a firm commitment to implementing UHC was made. During Zuma's first term (2009-2014) there were rising costs in the private healthcare sector and there was a shift in government economic thinking. To improve the healthcare system became an urgent government priority area. However, the government was open to private partnerships to achieve its healthcare delivery goals. The private healthcare sector wanted to benefit from the NHI system. The SACP's central committee report to the Special National Congress (December 2009) stated that,

> Private interests in the [healthcare] sector seriously explored ways and means of capturing the proposed National Health Insurance [NHI] Scheme through PPPs, by seeking to entice government's planned investment into the public health system through the rebuilding of hospitals and clinics via such private engagements.[40]

The Medium-Term Strategic Framework (MTSF, 2009), a government's programme in the electoral mandate period (2009 – 2014), stated that the electoral mandate was to "improve the nation's health profile and skills base and ensure universal access to basic services."[41] However, there was a low skills and expertise base in the public healthcare system. This had a negative impact on the nation's health profile. Free healthcare for all required a strategic human resourcing of the public healthcare system. The two-tiered healthcare system required a complete overhaul. The MTSF (2009) further held that,

> Improving access to health services and achieving better clinical and patient outcomes from the public health system is a central goal of government's healthcare services. The health sector saw significant increases in real expenditure in the 2004 – 2009 period, reflected in expanded infrastructure, upgrading of facilities and broadening the available package of health services. Nevertheless,

[39] Blade Nzimande, 'Roll back the corrupting intersection between private accumulation and public service!' *Umsebenzi: Voice of the South African Communist Party* (Johannesburg: SACP, October 2009), 3.

[40] South African Communist Party (SACP), in an article entitled: 'Together, lets defeat capitalist greed and corruption! Together, build socialism now,' published as the SACP's Central Committee Report to the Special National Congress (December 2009) in the first quarter by the *African Communist,* Issue No. 181, (Johannesburg: SACP, April 2010), 20.

[41] *Medium-Term Strategic Framework – MTSF* (Presidency: Republic of South Africa 2009-2014), 2.

> various challenges still face our healthcare system and efforts to improve access to health services and achieve better health outcomes will have to be stepped up. The poor quality of healthcare, aggravated by the burden of disease, calls for an overhaul of the health system.[42]

There remained gross inequalities in the South African healthcare system. Furthermore, in the 2009 – 2014 MTSF period, the aim was to transform the public health system in order to reduce inequalities in the healthcare system, improve the quality of healthcare and public facilities, boost human resources, step up the fight against HIV and AIDS, TB and other communicable diseases as well as lifestyle and other causes of ill-health and mortality.[43] Moreover, the MTSF (2009 – 2014, in Article 40.1), suggests that elements of strategy to transform the healthcare system and reduce the inequalities will include "phasing in a National Health Insurance (NHI) system within the next five years based on the principles of healthcare coverage for all, cost containment, equitable healthcare financing, compulsory/mandatory participation, risk equalization, and simplified administration;"[44] and that, "[a] critical starting point in introducing [the] NHI will be a revamp of the public health system, so [that] it progressively provides quality healthcare."[45]

In addition, the MTSF (2009 – 2014, in Article 40.2), maintains that the mandate was to increase institutional capacities to deliver [healthcare system] functions and initiate major structural reforms to improve the management of health services at all levels of healthcare delivery, but particularly hospitals.[46] This reengineering process involved the establishment of the Office of Health Standards Compliance (OHSC) to monitor both the quality of care and compliance with norms and standards for health facilities.[47] The NHI policy (Article 23 of the White Paper) states that, "The third and final phase of implementation will take place over the last four years and will focus on ensuring that the NHI Fund is fully functional. Health facilities that are eligible would have been certified by the OHSC and accredited by the NHI Fund."[48] To clarify, the OHSC will certify practitioners and practices and the NHI Fund will accredit

[42] *Medium-Term Strategic Framework – MTSF* (2009-2014), 20.

[43] *Medium-Term Strategic Framework – MTSF* (2009-2014), 20.

[44] *Medium-Term Strategic Framework – MTSF* (2009-2014), 20.

[45] *Medium-Term Strategic Framework – MTSF* (2009-2014), 20.

[46] *Medium-Term Strategic Framework – MTSF* (2009-2014), 20.

[47] *Medium-Term Strategic Framework – MTSF* (2009-2014), 20.

[48] NHI White Paper, 3.

them.

In 2010 there was another economic policy shift. The government introduced the New Growth Path (NGP, 2010).[49] The NGP states that, "Proposals to introduce [the] National Health Insurance [NHI], for instance, should reduce the share of the GDP spent on health, which is now extraordinarily high for a middle-income economy, while improving access for the majority."[50] The NGP (2010) further states that, "Investment in health, including effective measures to address HIV/AIDS [play a critical role in the long-run]. Government has prioritized health and education investment and delivery."[51]Access to healthcare services for the majority needs to be improved. However, free access to quality healthcare services needs to be emphasized. The NGP (2010) further asserts that, "Proposals to introduce [the] National Health Insurance [NHI], for instance, should reduce the share of the GDP spent on health, which is now extraordinarily high for a middle-income economy, while improving access for the majority."[52] In the year 2010, Cosatu called for the NHI system to be phased in. Cosatu's perspective was that,

> The mandate given to the ANC in the next five years includes the 10 Point Plan to transform the South African healthcare system, the centre piece of which is the implementation of the National Health Insurance (NHI). Cosatu supports the 10 Point Plan that has been proposed by the Department of Health. Nevertheless, there is a need for the advisory committee on the NHI to urgently conclude on [a] path of transition towards the NHI, and mandate the National Treasury to translate the commitment to the NHI into Rands and Cents, by making the necessary budgetary allocations to phase in the system.[53]

Upon Cosatu's call, one year later (2011), the South African government released the Green Paper on the NHI.[54] The National Treasury was consequently engaged by Cosatu to commit to

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[49] In the same year (2010) the National Planning Commission (NPC) was formed (Trevor Manuel was its chairperson, Cyril Ramaphosa became its deputy chairperson). The NPC (2010) produced the Diagnostic Overview.

[50] *New Growth Path – NGP*, (Republic of South Africa: Department of Economic Development, 2010), 41.

[51] *New Growth Path – NGP*, (Republic of South Africa: Department of Economic Development, 2010), 22.

[52] *New Growth Path – NGP*, 41.

[53] Congress of South African Trade Unions (Cosatu), *A growth path towards full employment: Policy perspectives on the Congress of South African Trade Unions* (Cosatu: Draft Discussion Document, 11 September 2010), 88.

[54] Choonara and Eyles, 'National health Insurance: SA's most progressive health reform to date,' 31. Furthermore, the unanimous adoption by the UN Human Rights Council (in 2011) of the *United Nations Guiding Principles on Business and Human Rights* (UNGP), according to Van der Ploeg and Vanclay, "has led to a growing awareness of the human rights

the phasing in of the NHI system.

4.4 Conclusion

This chapter traced the historical evolution of the NHI policy and the policy shifts within the ANC during the period of the democratic transition. It showed that the two competing healthcare systems survive ANC policy shifts. It provided data in order to prepare for Chapter 5. It also offered a historical analysis and showed that the concept of the NHI system, as a financing system for healthcare, evolved within the ANC. I hope to have provided context through having provided this historical analysis. What I have done is to document continual shifts in ANC policy documents with some implications on the healthcare system. What I see is that there is a need for serious rethinking. Thinking about healthcare has continually shifted. New policy documents were added but the ANC is struggling to work out its position.

The Department of Health (DoH) published the NHI Green Paper in August 2011, the NHI White Paper in December 2015, and the NHI Bill in May 2018. The focus of the next chapter is a discussion on the NHI policy and legislation in the context of the NHI Green Paper (2011), NHI White Paper (2015 – 2017), NHI Bill (2018) and the Medical Schemes Amendment Bill (2018). It shows that the NHI legislation establishes the NHI Fund as a financing and implementing mechanism of the NHI system.

responsibilities of business enterprises…Involvement in human rights violations and abuse now constitutes a business risk for companies." See: Van der Ploeg and Vanclay, 'A human rights-based approach to project induced displacement and resettlement,' in *Impact Assessment and Project Appraisal*, 34.

Chapter 5

Reflection and analysis of the contemporary situation on the NHI system

5.1 Introduction

The previous chapter traced the historical evolution of the NHI policy within the policy shifts in the African National Congress (ANC). It affirmed that there are two competing healthcare systems that survive ANC policy shifts. In it, I located the discourse on the NHI system in the historical policy shifts within the ANC. I showed that two healthcare systems developed in opposition to one another, one private (to service the minority) and the other public (to service the majority). Notably, there are forces in the ANC that are calling for the NHI system to be phased in and the NHI Fund established. As a result, policy and legislative documents have been published by the South African government.

This chapter offers a discussion of the National Health Insurance (NHI) policy and legislation in the context of the NHI Green Paper (2011), NHI White Paper (2015, 2017), NHI Bill (2018) and the Medical Schemes Amendment Bill (2018). The purpose of the discussion is to raise the question: can the NHI system and legislation bring about the stated goal? I argue that it cannot because of the contradictions – in Marxist terms – between treating healthcare as a *(i)* use-value and as a *(ii)* commodity. The NHI legislation establishes the NHI Fund as a financing (strategic purchasing) and implementing mechanism of the NHI system that will purchase healthcare in both the private and the public sector.[1] Thus, my aim is to show that there is a tension in the NHI policy and legislation. This tension inevitably arises because the private and the public sectors are contradictory. Therefore, I argue, a clearer policy must be articulated to resist a seemingly irresistible option to purchase healthcare in the private sector using the NHI Fund, so that the focus becomes improving the conditions of the public healthcare sector. Additionally, I also argue that a policy must be formulated to insist that healthcare is not a commodity but must be completely de-commodified and de-commercialized – and offered free by the state *only* in a single tier.

[1] A financing mechanism for healthcare in South Africa was initially designed for a poor white minority who could not afford to pay for quality healthcare in a racially segregated healthcare system. This idea has been carried over to a financing mechanism for all to access quality healthcare in a democratic and non-racial South Africa.

Lastly, privatization should not be permitted in the healthcare sector. The private healthcare system must be negated. The private healthcare sector must be brought into the legal ownership of the state if it is to receive any funds from the NHI Fund. Moreover, the private and public healthcare sectors are not static (existing side by side with no relation) but have a dynamic (inevitable interaction) and complex relationship that is effectively contradictory and in opposition. I challenge the effect of the neoliberal ideological underpinnings of the NHI policy and the NHI legislation: that of further collapsing the public healthcare sector.

5.2 NHI policy and legislation in South Africa

5.2.1 Tensions in the NHI policy

The main issue in this section is to show that there are tensions in the NHI policy – the earlier uncertainty and ambiguity is continued in the NHI Green Paper (2011), NHI White Paper (2015, 2017), NHI Bill (2018) and the Medical Schemes Amendment Bill (2018).

The key principle of National Health Insurance (NHI) policy as found in the NHI Green Paper (2011) is that, "access to [health] services must be *free at the point of use* and that people will benefit according to their health profile" (italics added).[2] According to the NHI policy framework, patients will gain access to the two healthcare systems (public and private) *for free*. The interrelation between the public and private healthcare systems is unworkable and detrimental to the public healthcare sector while profitable for the private healthcare sector. I am concerned about the policy of public healthcare services being offered to the majority of the population using private healthcare sector institutions and facilities. The private healthcare system was designed initially to maintain and secure privilege for a white minority (as substantiated in the previous Chapters). It was only later that the private healthcare system secured the privilege of quality healthcare for a minority that could afford it, irrespective of race. I argue that the proposed relation will in the end only benefit the private healthcare sector – and such a relation will never improve the public healthcare sector in its core. I am sceptical of the NHI system also as a mechanism to ensure access to private quality healthcare, instead of focusing only on improving the public healthcare system. This aspect of financing private healthcare dates back to the National Party (NP) and their concern to give poor whites access to quality healthcare. Thus, the NHI system has a history that dates back to the discussion of

[2] *National Health Insurance in South Africa: Policy paper* (Department of Health: Republic of South Africa, 2011), 16.

the National Health Service (NHS) in South Africa, before the ANC took over government.[3] The National Party (NP) leadership had a challenge of poor whites particularly in the rural parts of South Africa, this problem was referred to as the "poor white problem." Historically, a financing mechanism to create access to private healthcare services was discussed in view of the "poor white problem," not necessarily to resolve the challenges of the public healthcare sector in a racialized economic system.[4] It is this historical aspect that aids my understanding as to why the NHI's focus is not based on improving the public healthcare system but creating universal access to the private healthcare sector.

[3] During this period, the divide between "personal" and "public" healthcare services in South Africa's emerging racialized healthcare system persisted. Healthcare services were inequitable. There were offered along racial lines in urban and rural areas. "Personal" healthcare services were curatively orientated and were mostly delivered in racially segregated hospitals. Healthcare for South Africa's white minority was offered in a well-developed, richly resourced, complex network of urban public hospitals or within private facilities. There was an initiative to transform the fragmented and inequitable nature of the healthcare system in 1942 (by the South African Party). As shown in footnote 1 above, initially the conceptualization of the National Health Service (NHS) in South Africa was a result of the poor "white problem." Therefore, the discussion of the NHS focused on servicing whites only. The idea was based on ensuring that a mechanism was created for poor whites to access quality healthcare services. See: Daygan Eagar, Richard Cooke, Jonathan Levin, and Milani Wolmarans cite Coovadia H, Jewkes R, Barron P, Sanders D, McIntyre D, *The health and health system of South Africa: historical roots of current public health challenges*, 374(9692), (London: Lancet, 2009), 817–34.

[4] According to Virginia Zweigenthal, Leslie London, and William Pick, in 'The contribution of specialist training programmes to the development of a public health workforce in South Africa,' published in *South African Health Review 2016* (Durban: Health Systems Trust, 2016), (p.48) by 1944 the Gluckman Commission was set up which advocated for a unified National Health Service (NHS); its brief was to advise on the establishment of a National Health Service (NHS) for South Africa's population. The impetus for its establishment was government's recognition of the health problems of 'poor whites,' who had little access to healthcare, a phenomenon that had grown during the war. Gluckman identified four major problems in the organisation of healthcare: poor co-ordination due to the three-tier health system; maldistribution and shortages of human resources and facilities; an inappropriate emphasis on curative and institutional care; and a profit-orientated private practice focused on curative care in urban Europeans only areas. The Commission's proposals extended beyond the Health Department to sectors such as town planning, housing and education. It recommended the establishment of a Ministry of Health with a more "comprehensive scope," and a reorganised health service with policy-making and programming at all levels, within the NHS. This commission became known as the National Health Service (NHS) Commission. Dr Sidney Kark was appointed technical advisor to the National Health Services Commission (NHSC) or the Gluckman Commission, in 1942. The commission was led by Dr Henry Gluckman who became Minister of Health in 1945 to 1948 (under Jan Smuts). The Gluckman Commission recommended a National Health Tax that would provide *free at-the-point-of-service healthcare for all South Africans according to their needs*. This is a direct quote, reprinted verbatim in the NHI Green Paper of 2011 as the cornerstone of a new mythology of Gluckman's National Health Service as a pioneering and uniquely African concept that was actively snuffed out by the Afrikaner Nationalist Government, tacitly supported by the white professional classes seeking to defend their privileges. Forty-four community health centres were built between 1944 and 1946 under Smuts' rule, but any other proposals from the commission stagnated once the National Party was elected in 1948.

The decision to introduce the NHI system in South Africa was followed by the adoption of the National Development Plan (NDP, 2012) and congress resolutions from the African National Congress (ANC)'s 53rd Conference. However, the inclusion of private healthcare providers into a publicly funded system given their expensive costs is not progressive. There is a historical and contradictory (oppositional) relationship between the private healthcare sector and the public healthcare system in South Africa that dates to a racial-ideology-driven era. Therefore, the inclusion of private healthcare providers in a publicly funded system on the basis that there is no tension in the two healthcare sectors seems headed in the wrong direction. The private healthcare sector is interested in profit maximization not in offering public healthcare. Seemingly, the main component of the NHI system is that public healthcare will be provided through the private healthcare sector. In my view, this should not be the case. The private healthcare sector does not have the capacity nor the capabilities to provide public healthcare for all for free. In fact, such a model should not be permitted by the state. Especially in a case where the state is also providing a healthcare service. The nature of the problem in the NHI policy and legislation locates itself in this complex two-tiered dynamic. It is this two-tiered system that must be dismantled. The NHI system must involve the public healthcare sector *only* in a single tier.

The policy decision to include the private healthcare sector will constantly create an ideological challenge with offering free public healthcare through expensive private healthcare sector institutions. The public healthcare sector and the private healthcare sector are two necessary but conflicting variables operating in one system. The two variables inform the ideologically contradictory relationship within the two sectors. This relationship provides assumptions that present two decisive possible effects: *(i)* the further collapse of the public healthcare sector and *(ii)* the further expansion of the private healthcare sector in South Africa. I reiterate and emphasize these assumptions. The two sectors are not in isolation to one another they are in a relationship that forms part of a complex system in the healthcare economy that is based on a capitalist framework and free-market principles. Unfortunately, the NDP (2012) further confirms that, "[The financing of the NHI system will predominantly be] public, but delivery [will] typically [be] by a mix of public and private providers."[5] My view is that the private healthcare sector must finance itself – precisely because it is a private enterprise. The government must only finance the public healthcare sector, and not include financing the

[5] *National Development Plan (NDP) Vision 2030: Our future – make it work,* (Presidency: Republic of South Africa, 2012), 339.

private healthcare sector with public sector funds. Therefore, public healthcare delivery must not typically be in a mixture of public and private providers whilst funding is predominantly public. In the interim, people that prefer to acquire services from the private healthcare sector must do so at their own expense. Private healthcare sector users must not expect a subsidy from the government in order for them to access healthcare services in the private healthcare sector.

I am at variance with the policy position of the NDP (2012) in this regard, and to a certain extent to the ideological framework that informs the economic aspects of the NDP (2012) itself. It is important here to reiterate my point that there remains a tension in offering public healthcare services using private healthcare sector institutions or facilities. There is a malfunctioning that arises from the economic relations that typify the NHI system as a financing system for a two-tiered healthcare system. This tension is potentially a very powerful source of systemic change. The two variables (private healthcare sector and public healthcare sector) are effectively in opposition. Thus, I strongly disagree with the concept of "a public healthcare service" through "private healthcare sector delivery." The grounding of NHI policy and legislation is neoliberal orthodoxy. The Congress of South African Trade Unions (Cosatu) concurs with my point; it states that,

> Powerful vested interests that are grounded in neoliberal orthodoxy [have attempted] to shape the [NHI system] in their favour. If they succeed, the [NHI system] is unlikely to contribute to the transformation of the [healthcare system] in a way that effectively promotes the progressive realization of the right to healthcare for all.[6]

Cosatu affirms my view. Moreover, I agree that powerful private healthcare interests have succeeded to shape the NHI system in their favour. The NHI system in its current framework is unlikely to contribute to the transformation of the public healthcare system as envisioned by Cosatu. After many deliberations and comments on the NHI Green Paper (2011), and the NDP (2012), especially within the African National Congress (ANC), Cosatu, and the South African Communist Party (SACP), the NHI White Paper was published, four years later, in December 2015.[7] The NHI White Paper (2015) establishes the NHI system in South Africa to achieve

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[6] Louis Reynolds, 'Health for all? Towards a national health service in South Africa,' in a book entitled, *New South African Review 1: 2010: Development or decline?* (Chapter 14) Edited by John Daniel, Prishani Naidoo, Devan Pillay and Roger Southhall (Johannesburg: Wits University Press, 2010), 328.

[7] In September 2015, the United Nations (UN) General Assembly launched the 2030 Sustainable Development Goals (SDGs). Goal 3.8 of the SDGs is to "Achieve universal health coverage [UHC], including financial risk protection, access to quality

Universal Health Coverage (UHC). Thus, the NHI White Paper (2015) points out that, "The health services covered by [the] NHI will be provided free at the point of care."[8] Regarding this point (free at the point of care), there is no substantial deviation from the NHI Green Paper (2011). It is in taking this position forward that the NHI system, in the current neoliberal macroeconomic framework, represents a substantial policy shift.[9]

5.2.2 NHI Bill (2018) and the Medical Schemes Amendment Bill (2018)

I now look at the NHI Bill (2018) and its interconnectedness with the Medical Schemes Amendment Bill (2018).

After the NHI White Paper (2015) was released by the South African government, a revised NHI White Paper was published in June 2017. The NHI White Paper (2017) was integrated into the National Health Act and was published by the government (on the 28 June 2017) and signed into law by the former Minister of Health, Dr Aaron Motsoaledi. The National Health Act (2017) states that, "This [Act] lays the foundation for moving South Africa towards [Universal Health Coverage (UHC)] through the implementation of [the] National Health Insurance (NHI) and establishment of a unified health system."[10] The success of the NHI system in South Africa and the achievement of a non-discriminatory and universal access to free healthcare for all will depend on the proper functioning of a *unified* and free public healthcare system. But for such a unified healthcare system to exist, changes that may impact the private healthcare sector will have to occur, particularly in the medical aid scheme industry (or healthcare insurance sector). Most importantly, South Africa needs one healthcare system that offers high quality healthcare for all regardless of race or class – a universal system, wherein there will be no private healthcare sector. If the goal of a *unified* healthcare system in a single tier is to be achieved, the coexistence of private medical insurance and the NHI system

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essential healthcare services and access to safe, effective, quality and affordable essential medicines and vaccines for all." The term "affordable" gives an impression that healthcare is to be paid for but "financial risk protection" needs to be put in place by the government. The NHI White Paper was published by the South African government, 3 months later, in December 2015. Interestingly, the NHI White Paper (2015) proposed phasing out the two-tiered healthcare system by 2030.

[8] *National Health Insurance Policy: Towards Universal health Coverage*, (Department of Health: Republic of South Africa 2015), 9.

[9] However, I am concerned that the NHI system may have an inability to achieve a level of reorganization that overcomes racialized inequalities.

[10] *National Health Act of 2003, National Health Insurance Policy: Towards Universal health Coverage*, (Department of Health: Republic of South Africa 2017), 1. The NHI White Paper was incorporated into the National Health Act of 2003 (as is). At the time, the ANC was preparing to go to its elective conference in December 2017.

should be curtailed. The private medical insurance system currently caters for 8.8 million people in a country with a population of approximately 58 million people. There are millions of people that currently cannot access quality healthcare in the private healthcare sector. Moreover, the recurrent inequality of access to quality healthcare has a racialized historical pattern and class dimensions. Therefore, in a universal system, and given the potential universality of the NHI system, the private medical aid or private healthcare insurance system in its current framework in South Africa must cease to exist and the NHI system not be permitted to co-exist with it. In order to understand why I critique the NHI Fund I will provide a background to the NHI Bill (2018) by looking at the 2017 ANC National Conference.

The ANC held its national conference in December 2017, at Nasrec in Soweto, where the NHI policy was discussed. The conference resolved that the NHI system should be implemented. At the 2017 ANC conference, Cyril Ramaphosa was elected to become the president of the ANC. As president, he was mandated by the ANC to implement the NHI policy.[11] It is during Ramaphosa's presidency, that the South African government drafted the NHI Bill (2018) and simultaneously amended the legislation that governs the medical aid schemes. In May 2018, the former Minister of Health, Dr Aaron Motsoaledi, presented the Medical Schemes Amendment Bill [2018] to the Cabinet Committee for discussion. In the National Assembly, on 15 May 2018, Motsoaledi affirmed that, "The time has now arrived to finally implement Universal Health Coverage (UHC) through the National Health Insurance [NHI system]."[12] Motsoaledi in his address in parliament said:

> [I] was to present the NHI Bill [2018] and the Medical Schemes Amendment Bill [2018] to the Cabinet Committee for that Committee to recommend them to the full Cabinet on 23 May 2018, for them to be gazetted for public comment, and then later sent to Parliament to start the process of legislating. However, the President said he has taken a special personal interest in the NHI [system] and hence

[11] The ANC National Working Committee (NWC) initiated the removal of Jacob Zuma from power. Zuma was persuaded to resign from the state presidency, as he no longer was the president of the ANC. The ANC policy holds that the president of the ANC becomes the president of the state. Zuma, having completed his term as the ANC president in 2017 December, subsequently resigned from the state presidency, as the former president of the ANC. After the legal and parliamentary processes were followed for inaugurating a new state president was to become Cyril Ramaphosa. In his ascent to the ANC presidency, and consequently the state presidency, Ramaphosa took a special personal interest in the National Health Insurance (NHI) legislation.

[12] Dr Aaron Motsoaledi, former minister of health, national assembly, 'Debate on the health budget vote -16,' 15 May 2018, 16h15, 7.

> instructed that we put the [NHI Bill] in abeyance and not present it in his absence. [Therefore,] I have only presented the Medical Schemes Amendment Bill to the Committee. The two Bills will be released together as soon as the NHI Bill has been dealt with, the President leading from the front.[13]

Consequently, Ramaphosa was to lead the implementation of the NHI system "from the front." The National Treasury allocated: R 4,2 billion towards the implementation of the NHI system (until March 2021).[14] Challenges in the public healthcare system were to be addressed through the involvement of the private healthcare sector. Motsoaledi maintained that,

> Here at home, we will commence with the initial steps towards the implementation of [the NHI system]. I am pleased to report that the National Treasury has allocated funds to kick-start the process of addressing some of the challenges in the public health system. This is a sum of R4,2 billion over the MTEF allocated mainly for the National Health Insurance, Health Planning and Systems Enablement programme, financed through downward adjustments of the medical aid tax credits and rebates.[15]

During this period, Cabinet approved the Medical Schemes Amendment Bill (2018) first. Business Day (Wednesday, 30 May 2018) released an article entitled, "Medical scheme changes await NHI Bill." In the article Kahn states that, the Cabinet announced that it had approved the Medical Schemes Amendment Bill (2018).[16] Accordingly, after the Cabinet committee had met with president Ramaphosa, on Wednesday, 30 May 2018, the Cabinet approved the NHI Bill (2018), thereby approving the legislation of the NHI system within its contradictory framework. Thus, Kahn further reported that,

> The [NHI Bill (2018)] which was approved by the Cabinet last Wednesday has yet to be published in the Government Gazette…The [NHI Bill (2018)] does not provide any details about how the NHI [system] will be financed leaving that to the Treasury to determine. Instead it sets out the legal mechanism for establishing an NHI Fund, which will purchase services from accredited public and private healthcare providers. Accreditation will be provided by the Office of Health

[13] Motsoaledi, 'Debate on the health budget vote – 16,' 8.

[14] Kailene Pillay, 'Several imponderables may bedevil the NHI,' *The Star* (Wednesday, 24 June 2018), 4. This was corroborated by the former minister in the budget speech.

[15] Motsoaledi, 'Debate on the health budget vote – 16,' 9.

[16] Tamar Kahn, 'Medical scheme changes await NHI Bill,' *Business Day* (Wednesday, 30 May 2018), 4.

> Standards Compliance which will be implementing a new set of norms and standards in 2019 that include the private sector for the first time.[17]

There was a general consensus that the NHI system was to include the private sector. The draft NHI Bill had set out the legal mechanism for establishing an NHI Fund which will purchase services from accredited public and private healthcare providers. The above paragraph captures the complexity of the NHI system's development within a matured free-market system, especially in the NHI system's inclusion of the private healthcare sector.

5.3 Opposition to the NHI policy and legislation

5.3.1 Reaction to the NHI system by a pressure group

Next, I show that there was a reaction to the NHI system by a pressure group comprised of healthcare practitioners and academics. This reaction was internal to the healthcare industry, but not internal to the ANC.

A pressure group launched an onslaught against the former Minister of Health (Motsoaledi) in a fierce fight disapproving of the NHI policy and legislation. There were calls for Motsoaledi to be dismissed. In an article released by *The Star* entitled: "Knives out for Motsoaledi" Sifile and Mashaba confirmed that, "The onslaught on Motsoaledi is coming from a pressure group of professional health practitioners and academics."[18] The 99 individuals in a list [seen by *The Star*] are calling for a review of the newly approved NHI system. Motsoaledi retaliated, saying that the opposition to the NHI system and calls for his dismissal were being orchestrated by medical insurance companies, which did not want the NHI system to be implemented.[19] According to Sifile and Mashaba, the pressure group "blasted the public health management and [the NHI system] presentation which Motsoaledi made to the [Cabinet]."[20] Such opposition was not external or accidental to the introduction of the new NHI system. It was an internal opposition to the NHI system within the South African private healthcare economy and it formed part of the internal contradictory nature of the private healthcare sector.

Dr Amilcar Juggernath, a member of the pressure group said that, "[They] are a collective who wanted to collaborate in the fight for better healthcare."[21] The group submitted a 9-page

[17] Kahn, 'Medical scheme changes await NHI Bill,'4.

[18] Lindile Sifile and Sibongile Mashaba, 'Knives out for Motsoaledi,' *The Star* (18 June 2018), 1.

[19] Sifile and Mashaba, 'Knives out for Motsoaledi,' 1.

[20] Sifile and Mashaba, 'Knives out for Motsoaledi,' 1.

[21] Sifile and Mashaba, 'Knives out for Motsoaledi,' 1.

document. In the document, according to Sifile and Mashaba, "the group argued that the creation of the NHI [system] was unclear. It was 'unresearched' and merely there to address the current crisis with no future plans…[and that the NHI system] has been characterized by lack of transparency, equivocal National Treasury support and paradoxically, a deteriorating public service."[22] It is not surprising that the pressure group said that, "[they] support Universal Health Coverage (UHC) which [it] believed would have been cost effective and easily accessible to all compared to the NHI [system]."[23] The opposition group seemed to have made an implicit distinction between UHC and the NHI. But Motsoaledi understands these two to be related. For Motsoaledi, the NHI system is a mechanism to achieve UHC. But, the implementation of the NHI system may not achieve UHC. In my view, to achieve UHC the conglomerate private healthcare sector's involvement and the inclusion of private healthcare providers within the national healthcare system must be negated.

The NHI system must become an organized class-conscious worker-centred mechanism for a socialist mode of healthcare production (free healthcare) within one (single-tiered) public healthcare sector-led healthcare system. An alternative position may continue the ever-increasing misery that is experienced currently in a deteriorating public healthcare system operating within a capitalist and exploitative system. The majority of people residing in poorer areas and provinces (in informal settlements, townships and rural areas) utilize weak, even collapsed, public healthcare systems and receive poor, low quality, healthcare services as compared to what private healthcare services are offering to the minority that can afford it. In addition to such poor healthcare services in the areas where the majority resides, public healthcare systems are inefficient, lacking equipment and technology; have long queues and long waiting lists for procedures; have none or fewer specialists on site and are seen to offer a lower quality of healthcare services by comparison to the private healthcare sector. The new healthcare system regime that is introduced by the NHI Bill (2018) and Medical Schemes Amendment Bill (2018) is the financial protection of all in South African society from the exorbitant costs of accessing quality private healthcare services in South Africa. Yet, it should be designed to concentrate on the healthcare systems that offer healthcare to the entire population. But, the overall aim of the NHI policy and legislation is to achieve UHC and to aid the government in offering private quality healthcare for all for free (or at no cost) at the point

[22] Sifile and Mashaba, 'Knives out for Motsoaledi,' 1.

[23] Sifile and Mashaba, 'Knives out for Motsoaledi,' 1.

of care, using the NHI Fund as financing mechanism.[24]

The NHI system must seek to improve the life expectancy and quality of life of all in the population (citizens and non-citizens) through the provision of UHC via the public healthcare sector *only.* Policy action should be taken to phase-out the two-tiered healthcare system and phase-in one national healthcare system, if the goal of UHC and offering free healthcare services to all is to be effectively achieved in South Africa. But this may not be the case since others believe that the private healthcare sector must be kept intact and that services must be purchased from it by the state. Therefore, if this is to be the case, then the NHI must operate like a massive medical insurance scheme. Malan states that,

> The [National Health Insurance (NHI)] will be like a huge, state funded medical [aid] scheme that buys health services from public and private health facilities…The scheme is being phased in over two five-year periods and one four-year period ending in 2026. [South Africa is] currently in the second phase (2017-2022), of which one of the objectives is to put the legislation in place for the NHI to be implemented.[25]

If the NHI is implemented in its current framework, where it operates like a giant medical aid, then access to premium private healthcare for every South African will become a dream come true, but negative factors such as collaboration between the public and private sectors and the unavailability of a skilled workforce and management may arise.[26] There is a view that the tension between private and public healthcare is unnecessary, and that in pursuing universal healthcare, there is no doubting that the conglomerate private healthcare sector can offer solutions to a struggling public healthcare sector.[27] But, the private healthcare is not an isolated proposition. Neither is it absolute. In the non-Marxist sense, it is standard to treat the two (public and private) healthcare sectors ahistorically and abstractly and consider them and their interconnectedness to be static and not dynamic.

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[24] The NHI's characteristic methods extend and deepen marketization through the concept of offering a public health service through private sector delivery.

[25] Mia Malan, Will the NHI actually work? *Mail & Guardian*, 29 June to 5 July (2018), 21. Malan asserts that, "The National Health Insurance (NHI) scheme is coming, whether you like it or not. And so is the end of your medical aid in its present form. That's if South Africa's NHI and Medical Schemes Amendment Bills, which were published last week and are now open for public comment, are passed by Parliament in their current forms."

[26] Kailene Pillay, 'Several imponderables may bedevil the NHI,' *The Star*, Wednesday, 24 June 2018, 4.

[27] Editor's review by Ron Derby, 'Time for our health minister to bridge the trust deficit,' *Sunday Times*, Business, Opinion and Bits, 2.

The SACP defended Motsoaledi against the pressure group's onslaught and called for the public release of the NHI Bill (2018). The NHI Bill (2008) was consequently gazetted by the South African government. The former Minister of Health (Motsoaledi), on Thursday, 21 June 2018, released both bills (NHI Bill and Medical Schemes Amendment Bill) for comment.[28] Interested parties were granted 2 months to make submissions and comments on both bills. The National Department of Health (NDoH) considered the Medical Schemes Amendment Bill (2018) as an interim measure. The two bills introduced a healthcare financing system reform to create a unified healthcare system in South Africa. The NHI Bill (2018) became essentially a legalization of the NHI White Paper (2017). Most importantly, the NHI Bill (2018) legislates for the formation of the NHI Fund. The NHI Bill (2018) creates an environment in which business in the healthcare industry can flourish. But, Natalie Zimmelman (South African Society of Anaesthesiologists [Sasa]'s chief executive) said that she found the former Minister of Health's "aggressive rhetoric" about the private sector "frustrating," and that the NHI system had to be implemented in a "rational" manner where the realities of a struggling public healthcare system had to be acknowledged.[29]

Motsoaledi has acknowledged the challenges within the public healthcare system and holds that these challenges should not deter the government from implementing the NHI system.[30] The two bills aim to shape the new pattern of state preferences in the South African healthcare system. Motsoaledi maintains that, "'We are painfully aware of the fact that some believe that even before we open our mouth about [the NHI system], we must sit and fix the ailing public healthcare system first.'"[31] The minister here acknowledged my point, but fixing the ailing public healthcare system first is unlikely from Motsoaledi's point of view. There is an expectation of mutuality and cooperation between the private healthcare system and the public healthcare system, and that mutual interests will increase with greater interdependence. Yet,

[28] Katherine Child, 'Doctor exodus feared as NHI proposes bold cure,' *Sunday Times*, 24 June 2018, 6. The former Minister of Health (Motsoaledi), on Thursday, 21 June 2018 released both bills (NHI Bill and Medical Schemes Amendment Bill) for comment.[28] Business Day (Wednesday, 11 June 2018) released an article entitled, "Cabinet approves an NHI [Bill] which is thin on details." The article states that, "Cabinet has approved the long-awaited National Health Insurance (NHI) Bill, the government's first and most crucial piece of legislation for implementing its goal of universal healthcare."[28] The NHI Bill (2018) and the Medical Schemes Amendment Bill (2018) was consequently discussed and approved by Cabinet and both bills were gazetted and consequently released for public comment simultaneously. The NHI Bill (2018) was published and gazetted by the South African government in (21) June 2018.

[29] Khaya Koko, 'Medical specialists threaten to emigrate over NHI,' *The Star*, 27 June 2018, 1.

[30] Koko, 'Medical specialists threaten to emigrate over NHI,' 1.

[31] Koko, 'Medical specialists threaten to emigrate over NHI,' 1.

the relations between the races and classes that both sectors serve, and the historical and dialectical relationship that both systems have, is a contradictory one.

The private healthcare system becomes abstract only when it is considered out of its own context, and when viewed in isolation. Moreover, the capitalist production of private healthcare as a commodity occurs within an unequal system of social and economic relationships. In such a system, different competitors (as healthcare producers) offer the same kind of service. This service is offered through a socioeconomic division of labour in which healthcare is commercialized. As a result, the moments of transformation within the healthcare system that define dialectical movement become part of the struggle and contradictions of this actuality. Though dialectical logic transcends static assertions regarding the two systems it does not reject the principle of separate identity, it gives it content. The private healthcare system currently charges exorbitant prices. If private medical aid schemes are permitted to co-exist with the NHI Fund as the NHI Bill (2018) and Medical Schemes Amendment Bill (2018) seems to suggest, then an important ideological factor underpins the two bills: that of neoliberalism. Neoliberal ideology governs the private healthcare sector, and it is now also a form of South African governmentality. However, in the South African case, the private healthcare system is not merely self-subsistent but exists in contradictory relation to the public healthcare system. What is seemly important in the NHI policy and legislative discussion is that the medical aid schemes must remain purchasers of private healthcare. Relatedly, both bills introduce a uniform tariff and price control for both the public and private healthcare systems. Malan states that,

> [If] the NHI Bill is passed, the cost of [healthcare] services will become lower. Private-sector health professionals who participate in the [NHI system] will be paid in fundamentally different ways: they will only be able to charge prescribed NHI rates for their services. Currently doctors and dentists practicing privately can charge whatever they like, because there are no set fees. For more than a decade the government has tried to impose such rates, but, each time, the private sector has instituted court proceedings and won.[32]

The first untested assumption is that that the NHI system will lower the rates that the private healthcare sector is currently charging. Secondly, that the NHI Fund will purchase services in both systems at the same price, and pay healthcare professionals the same amount, regardless of which system they operate in. Thirdly, competition in the healthcare industry will be

[32] Malan, Will the NHI actually work? 21.

eliminated due to set tariffs (uniform tariffs and price control) for healthcare facilities. Hence, according to Malan,

> [The former Minister of Health] has been instrumental in launching a Competition Commission market inquiry into what he considers exorbitant pricing in the private healthcare sector. But even in this case, the private sector has managed to drag out the announcement of the outcome of the investigation for almost three years. The inquiry was supposed to have concluded in December 2015, but the results [were] now expected only in [July 2018].[33]

A uniform tariff and price control system are two important elements of the NHI system. If there is a planned cap on what doctors and hospitals can charge and prices in the private healthcare system are controlled (and there will be standard fees for both the private healthcare sector and the public healthcare sector) then a fourth assumption is that the costs of private healthcare will decrease, and more people will access the private healthcare sector through the NHI Fund (via the NHI Card).

Even if these four assumptions were proven to be the case, in the current framework entailed in the two bills, more opportunities are created for private healthcare sector expansion. The resultant is that state patients will flow towards the private healthcare sector because of its perceived quality and its privileged status. This resultant lies within the logic of "decanting the heavy load" of state patients to the private sector. It further assumes that after the flow of state patients to the private healthcare system there will be enough space in the public healthcare system to then fix the problems, seeing that there will be a "lighter load." This logic is based on a flawed assumption. In this regard, it is important to emphasize that the NHI system in South Africa must be used to improve the conditions of the public healthcare system *only* without the involvement of the private healthcare sector. I emphasize that public sector finance from the NHI Fund needs to be invested into the improvement and expansion of the public healthcare sector *only*. If strategic purchasing from the private sector occurs (contracting private healthcare personnel and facilities through direct active purchasing) then state patients in the public healthcare sector may be transferred to the private healthcare sector. This will increase patient volume for the private healthcare sector. Again, the result maybe the expansion of the conglomerate private healthcare sector. A further collapse of public healthcare systems may occur. The notion that the government shall have "more room" to sort out its problems in

[33] Malan, Will the NHI actually work? 21.

the public healthcare sector is false. Instead, there may be further human resource migration to the private healthcare sector. Hence, large healthcare companies' shares recover (instead of reacting negatively towards the introduction of the NHI Fund).

My central argument is that healthcare is a use-value; therefore, it should not be treated as a commodity (it must be de-commodified) and must not be given exchange-value and then traded in the free-market system (it must be de-commercialized). Currently as is the case, or shall be the case with the NHI Fund, as currently formulated in the NHI Bill (2018), the commodification and commercialization of healthcare in the South African healthcare economy is kept intact. Malan, anticipating the problems, asks: "How will the unions react when private facilities are co-opted at the expense of government hospitals and clinics, with unionised workers whose services would now [not] be used?"[34] The unions will react negatively. Malan further states that, "With critically understaffed government facilities in many provinces, and South Africa's shortage of doctors and nurses, [it is] uncertain where the required number of professionals will be recruited from."[35] There is no clear strategy for human resources development both in the NHI policy (2017) and the NHI Bill (2018). Both documents are silent on this. Yet, such a strategy is imperative to the sustainability of the NHI system.

The pressure group's document came after the former Minister of Health (Motsoaledi) presented to the South African Communist Party's (SACP's) Central Executive Committee (2 June 2018). Sifile and Mashaba further maintain that the minister's presentation to the SACP, "claimed that billions [of rands] were being channelled to private healthcare companies at the expense of the poor."[36] The former Minister of Health (Motsoaledi) was correct to submit such a claim. It has become clear that the conglomerate private healthcare sector in South Africa is sustained through government funds. Yet, there is a false view that the "healthy and wealthy subsidise the poor."[37] Kahn, who also holds such a view suggests that the NHI system aims to provide free healthcare to everyone at the point of delivery, financed in a way that sees the healthy and wealthy subsidise the poor and the sick.[38] This is an incorrect view. Instead, in the private healthcare system, the government is subsidizing the middle class and the upper classes, the rich and the wealthy. Private hospitals and private clinics are currently being subsidized by

[34] Malan, Will the NHI actually work? 21.

[35] Malan, Will the NHI actually work? 21.

[36] Sifile and Mashaba, 'Knives out for Motsoaledi,' 1.

[37] Sifile and Mashaba, 'Knives out for Motsoaledi,' 1.

[38] Kahn, 'Medical scheme changes await NHI Bill,'4.

the government, including private medical aids. There are 8.8 million lives that are covered in the private healthcare sector.[39] The concrete contradictions of the capitalist system within the healthcare economy can no longer be covered up; they need to be exposed, and the capitalist system dismantled. Motsoaledi has explained to the SACP and Cosatu that 8.5 percent of the country's GDP went to the healthcare system of which 4.4 percent went to the private healthcare sector which serves only 16 percent of the population. According to Motsoaledi, members of medical aid schemes currently fork out R29 billion in co-payments partly subsidized by the government through tax rebates.[40]

5.4 Medical Schemes Amendment Bill (2018)

5.4.1 Complications and contradictions

The Medical Schemes Amendment Bill (2008) is an important factor in the implementation of the NHI system. It has a knock-on-effect on the NHI system. It proposes a series of healthcare insurance reforms. One element of such reform that is crucial in implementing the NHI system is the removal of co-payments (when a medical aid scheme does not cover 100% of costs and medical scheme members have to cover the shortfall).[41] In future, medical aids will be required by law to bill members differently. Those who earn more will pay more. Malan states that,

> In the period up to 2026, when the NHI will be fully implemented the minister wants medical schemes to align themselves with what the NHI will eventually look like. The Medical Schemes Amendment Bill, for instance requires medical aids to radically change the way in which they bill members. They will no longer be able to charge everyone the same rate for the same package; those who earn more will pay higher premiums. Medical schemes will also have to scrap co-payments; they will have to pay members' medical bills in full.[42]

The removal of co-payments is a knock-on-effect of the NHI system. It is a result of the interaction between the NHI Bill (2008) and the Medical Schemes Amendment Bill (2008). The amendment means that every cent charged to the patient must be settled fully by the medical aid scheme and the patient should not be burdened with having to pay out-of-pocket.[43]

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[39] Child, 'Doctor exodus feared as NHI proposes bold cure,' 6.

[40] Du Preez, Medical aids face costs crunch as bill shakes up benefits, rates, 1.

[41] Kailene Pillay, 'Several imponderables may bedevil the NHI,' *The Star,* Wednesday, 24 June 2018, 4.

[42] Malan, 'Will the NHI actually work?' 21.

[43] Pillay, 'Several imponderables may bedevil the NHI,' 4.

The point is that private medical aid schemes must have no significant role to play as instruments for the few (who can afford them) to access an expensive private healthcare system. As I mentioned earlier, the private healthcare system is not abstract, isolated, static, and unchanging. It is both abstract and concrete and as such it forms a major part of the healthcare economic system and its interactions. The Medical Schemes Amendment Bill proposes that *(i)* medical aid schemes be obliged to pay claims in full and with no co-payments; *(ii)* charge wealthier members more in contributions to subsidize the contributions of the lower earners; and *(iii)* extend the prescribed minimum benefits to include primary and preventative healthcare.[44] Jill Larkin (GTC broker who analyses medical bills) maintains that to compel medical aid schemes to pay for everything would be unaffordable and would destabilize them, "if the law makes medical aids unsustainable, what will happen to members of medical aid schemes? They will revert to the [state] and become [state] patients."[45] Private-sector healthcare companies need to decide for themselves how to proceed.[46]

The SACP released a statement (21 June 2018) to welcome the release of the NHI Bill (2018) and the Medical Schemes Amendment Bill (2018). In the statement, the SACP states that the root causes of the problems in the healthcare system lie in our fragmented and wasteful unequal multi-tiered healthcare system particularly in healthcare funding. Amendments to the Medical Schemes Act released by the former Minister of Health are aimed at ensuring that medical aid schemes remain affordable and viable until the NHI Fund is in place.[47] The proposals aim to cut costs to consumers but analysts warned this could destabilise medical aid schemes, leaving less money for private healthcare, which is accessed by 8.8 million South Africans that are using medical aid schemes.[48] Anderson asserts that, it is not possible for medical aid schemes to pay for everything with no co-payments, the only way for medical aid schemes to afford to pay more in the event of no co-payments is to increase premiums.[49]

I mentioned earlier that one element of the NHI system is the removal of co-payments. But there are other elements that are introduced by the Medical Schemes Amendment Bill (2018) in the system that also need to be mentioned. These are: the expansion of prescribed minimum

[44] Preez, 'Medical aids face costs crunch as bill shakes up benefits, rates,' 1.

[45] Katherine Child, 'High costs mar medical bill,' 4.

[46] Preez, 'Medical aids face costs crunch as bill shakes up benefits, rates,' 1.

[47] Laura du Preez, 'Medical aids face costs crunch as bill shakes up benefits, rates,' *Sunday Times*, Business Times section, 24 June 2018, 1.

[48] Katherine Child, 'High costs mar medical bill,' *Sunday Times*, Business News, 4.

[49] Child, 'High costs mar medical bill,' 4.

medical benefits; regulation of broker fees; charging premiums according to income; and the removal of medical tax. Thus, if co-payments are removed; prescribed minimum medical benefits expanded; broker fees regulated; wealthier members charged more to subsidize lower earners; and medical aid tax credits are removed, then in my analysis medical aid schemes will become unsustainable and unaffordable (or their existence will be threatened and the result will be annihilation). The effect is that costs for medical aid schemes will be raised; private medical aids will be forced to increase medical aid premiums to cover their increased costs (this means full payment by medical aids).

What makes healthcare capable of being bought and sold is the fact that besides healthcare being a specific type of service it has the characteristic of being worth something in the market. Therefore, the conglomerate private healthcare sector makes its profits by commodifying healthcare. The conglomerate private healthcare sector simply wants to expand to the limit, to gain control of the South African market, to become monopolists, and to squeeze as much profit as possible out of the South African healthcare economy. According to Sifile and Mashaba, "R46.7 billion was allegedly spent on government employees' medical aid schemes, with the remaining 4.1% of the GDP going to a public healthcare sector that accommodated 84% of the population."[50] In an entire population of 58 million, 84% are covered by the public healthcare sector. The NHI system, when implemented needs to do away with the need for government to subsidize contributions to medical aid schemes for its own employees.[51] Warwick Bam (insurance analysist at Avior Capital Markets) said that if medical aid schemes were destabilised it would undoubtedly have a negative effect on hospital groups and healthcare personnel as medical aids are the largest buyers of hospital services.[52] Regarding healthcare personnel, the former Minister of Health (Motsoaledi) asserts that there are a lack of skills and limited specialists in the public healthcare sector. Therefore, the state shall contract specialists from the private sector to help the hospitals in the public sector.[53]

There remains an ideological problem in the conceptualization of the NHI system.

[50] Sifile and Mashaba, 'Knives out for Motsoaledi,' 1.

[51] Preez, 'Medical aids face costs crunch as bill shakes up benefits, rates,' 1.

[52] Child, 'High costs mar medical bill,' 4.

[53] Dr Aaron Motsoaledi maintained his position that doctors and specialists in the private healthcare sector will get heavily involved in the NHI system (see: Motsoaledi, Debate on the health budget vote – 16, 15). I disagree with the minister's position on this matter. On all occasions when I met him during his presentations on the NHI policy I raised this issue that I saw an ideological contradiction in this. My view is that it should be doctors and specialists in the public healthcare sector that must get heavily involved in the NHI system.

Ideologically, it is not a matter of a self-contained private healthcare system that has merely a contingent relation to the public healthcare system. The two healthcare systems are incompatible (in fact they are in opposition). The NHI Fund seeks to function within a neoliberal and capitalist economic framework wherein there are capitalist conditions of healthcare production. The two healthcare sectors are mutually antagonistic. They are contradictory aspects of a single totality. The risk of the two bills is that removal of co-payments and expanding of medical aid benefits would raise costs for schemes and increase contributions that are required from members. This would mean lower membership as the less well-off will struggle to afford the increased premiums especially if the medical aid tax credit is removed. Michelle David (director of Norton Rose Fullbright) said that doctors in private practice would not want to be told what to charge. The NHI system is not likely to be accepted by all stakeholders, private doctors, and especially private hospitals. It is unacceptable to them that the NHI Fund, as largest purchaser of healthcare services, will also be able to set tariffs.[54] If this is to be the case, then doctors in private practice are ready to oppose the fixed tariff provisions in the bill in court.[55] Malan maintains that,

> Based on the private sector's past behaviour, the minister can expect court case after court case from organisations representing health professionals for essentially forcing them to charge lower, prescribed rates. Medical schemes will also go to court to fight for their existence. Both groups will be represented by top lawyers and will try and postpone the finalisation of the bills and their content for years to come.[56]

Chris Archer (chief executive, SAPPF) maintained that around 3000 doctors in private practice who are members of the South African Private Practitioners' Forum (SAPPF) will simply refuse to take part in the NHI project.[57] The SAPPF would go to court to oppose any attempt to introduce across-the-board tariffs.[58] This implies that private healthcare professionals may not agree to be paid low rates for their privately provided healthcare services. Graham Anderson (principal officer of Profmed Medical Scheme) warned that if doctors were not happy

[54] Child, 'Doctor exodus feared as NHI proposes bold cure,' *Sunday Times*, 24 June 2018, 6.

[55] Kailene Pillay, 'Several imponderables may bedevil the NHI,' *The Star*, Wednesday, 24 June 2018, 4.

[56] Malan, Will the NHI actually work? 21.

[57] Pillay, 'Several imponderables may bedevil the NHI,' 4.

[58] Pillay, 'Several imponderables may bedevil the NHI,' 4.

with the tariffs they had to charge they would emigrate.[59] Moreover, medical aids could not afford to cover costs in full and damaging them would have a negative effect on private hospital groups.[60] Nearly 500 anaesthetists from public and private hospitals are threatening to leave the scarce and critical profession or emigrate should the proposed NHI system be implemented.[61] Anderson further maintains that, "'Private healthcare is an essential service. If they are going to thrash the private sector [*sic*] to get the public sector up and running, doctors are going to go. If the doctors emigrate then other professionals, who can afford to leave, will go because they want healthcare for their children.'"[62]

The NHI system is facing major criticism from private healthcare providers as well as healthcare industry providers.[63] The South African Medical Association (Sama) also raised concerns about the NHI system. They held that the NHI system should not lower the quality of care that medical aid beneficiaries currently enjoy (8.8 million people).[64] Mzukisi Grootboom (Sama chairperson) called for a duplicative medical aid scheme cover to avoid a violation of rights to quality healthcare.[65] Lance Lasersohn (vice president of Sasa) said that South Africa had only 2.5 anaesthetists for every 100 000 patients (5 specialists per 100 000 are recommended by the World federation of Anaesthesiologists).[66] Coupled with the bill's goal of shared resources between the public and the private healthcare sector was the reason for specialists' fears.[67] Lasersohn added that, "[he] has received calls from members over the last week saying: 'It's time [to] go.'"[68] Hence my argument: the private healthcare system should not be contracted to the public healthcare system through the financing mechanism of the NHI Fund. The two systems are not only related or interconnected to each other; they are in a constant process of conflict in their interaction. The former Minister of Health (Motsoaledi) suggested on the contrary that,

> [Since] there is a grave shortage of Psychiatrists and Psychologists in the public

[59] Child, 'Doctor exodus feared as NHI proposes bold cure,' 6.

[60] Child, 'High costs mar medical bill,' 4.

[61] Khaya Koko, 'Medical specialists threaten to emigrate over NHI,' *The Star*, Wednesday, 27 June 2018, 1.

[62] Child, 'Doctor exodus feared as NHI proposes bold cure,' 6.

[63] Koko, 'Medical specialists threaten to emigrate over NHI,' 1.

[64] Koko, 'Medical specialists threaten to emigrate over NHI,' 1.

[65] Koko, 'Medical specialists threaten to emigrate over NHI,' 1.

[66] Koko, 'Medical specialists threaten to emigrate over NHI,' 1.

[67] Koko, 'Medical specialists threaten to emigrate over NHI,' 1.

[68] Koko, 'Medical specialists threaten to emigrate over NHI,' 1.

> sector…[and] a lack of space in [mental health] facilities…[and that because of this shortage of Psychiatrists and Psychologists]…[the] few specialists available to the public sector are concentrating their efforts on serious Psychiatric illnesses…[Therefore, in] trying to solve these two problems, [we] shall use this money to contract 52 Psychiatrists and 71 Psychologists from the private sector to help clear [the] backlogs.[69]

The private healthcare sector is determinate and concrete and has its own identity only by maintaining itself distinct from the public healthcare sector (which it opposes). The concrete contradiction between these two sectors is the root cause of the dysfunction in the public healthcare sector. There are also race and class contradictions. Contrary to Motsoaledi's position, the National Education Health and Allied Workers' Union (Nehawu) has called for a halt to any form of privatisation, be it through private-public partnerships or outsourcing or otherwise.[70] This has created fierce ideological contestation. The concept of the NHI system has brought about the interconnection of various conceptual and economic categories. Race and class as conceptual categories are the ruling material force of South African society. The race and class which owns the means of healthcare production has ownership and control of the healthcare system and the healthcare economy. The challenge is that in a capitalist system, the *differentia specifica* is the buying and selling of labour power. I do not see the cooperation and interconnectedness of the two sectors as positive. To offer public healthcare services using the private healthcare sector for delivery of such services creates an appearance of unity of the two sectors (a *unified* system), as if the reality of opposition does not exist within such a unity. Moreover, for service providers to be accredited by the NHI Fund they must comply with specific criteria to meet the needs of users and be in possession of a certificate that is issued by the Office of Health Standards Compliance (OHSC) and other relevant proofs of registration. Malan maintains that,

> In their present state, many state hospitals and clinics [will not] qualify to be part of the NHI. Because the NHI will be paying facilities directly for their services and not through provincial health departments, disqualified facilities are likely to run short of funds to pay health workers salaries. The NHI Bill specifies that all

[69] Motsoaledi, Debate on the health budget vote – 16,14.

[70] I was present in the meeting between the former minister of health and Nehawu's subcommittee on the NHI. The former minister of health was invited to present at this meeting. He presented to the delegates on the NHI system. Dr Motsoaledi and I disagree ideologically regarding how we should advance regarding the NHI system in South Africa.

> facilities that would like to be accredited for the NHI would need to pass an inspection by the Office of Health Standards Compliance, an organisation that monitors the quality of healthcare.[71]

At this stage, 5 state facilities out of 696 have passed the OHSC inspection in the period between 2016 and 2017; yet there are 3 880 public healthcare facilities that need to pass regular inspections by the OHSC.[72] The lowest estimate of private healthcare facilities that need to be inspected by the OHSC is 33 200.[73] According to Malan,

> The office conducted inspections of about 700 of the country's almost 4000 government health establishments in 2016/2017. In the Eastern Cape, the province in which the highest number of facilities were inspected, almost all clinics and community healthcare centres were "non-compliant" or "critically non-compliant" with an acceptable standard of healthcare.[74]

Public and private healthcare service providers accredited by the NHI system must deliver healthcare service benefits at an appropriate healthcare level to users who are in need and are entitled to benefits that have been purchased by the NHI system on their behalf. Notably, people will not be able to access the NHI system unless they are registered as users of the NHI Fund.

5.5 NHI Fund as an implementing mechanism

5.5.1 A subsystem of the NHI system

The NHI system is abstract and the NHI Fund (a sub-system) shall be established to be more concrete. The NHI Bill (2018) establishes the NHI Fund to be an autonomous public entity that is governed by Section 3(A) of the Public Finance Act.[75] The NHI system is therefore the main system of interest. The NHI Fund is a sub-system of the NHI system. Effectively, the NHI Fund is an implementation mechanism of the NHI system. The NHI Bill (2018) clarifies the functions of the NHI Fund, its powers, and regulates who will benefit from the NHI Fund. The NHI Bill

[71] Malan, Will the NHI actually work? 21.

[72] Child, 'Doctor exodus feared as NHI proposes bold cure,' 6.

[73] Child, 'Doctor exodus feared as NHI proposes bold cure,' 6.

[74] Malan, Will the NHI actually work? 21.

[75] The NHI Fund will have its own national offices equipped with own investigating unit to be established by the Chief Executive Officer (CEO) of the NHI Fund. The investigating unit shall make recommendations to the CEO. The objective of the NHI Fund is to protect users against financial risk and finance Universal Health Coverage (UHC).

(2018) also deals with the Board composition.[76] It provides a framework for the active purchasing of healthcare services by the NHI Fund on behalf of users. The term *user* means a person receiving treatment in a health establishment and entitled to healthcare benefits (as defined in Section 1 of the National Health Act).[77] The NHI Fund is a single strategic public purchaser and financer of healthcare services in the healthcare economic system to ensure a fair use and equitable distribution of healthcare services. Therefore, the NHI Fund will actively purchase public and private healthcare services and products on behalf of the public healthcare sector. Such services and products shall include: (1) medical equipment, (2) medical devices, (3) medical supplies, and (4) healthcare technology, including (5) complimentary medicine, and (6) scheduled substances for medical purposes on behalf of patients.[78] However, regarding purchasing of healthcare services the NHI Bill (2018) states that,

> The NHI Fund will transfer funds directly to certified and contracted central, provincial, regional, specialised, and district hospitals based on a global budget or Diagnostic Related Groups as determined by the Minister of Health in consultation with the National Health Council and the Board from time to time as required.[79]

Under the NHI Bill (2018), the NHI Fund will be the largest purchaser of healthcare services in South Africa and consumers will have to contribute to it.[80] The NHI Bill (2018) states that, the [NHI Fund] shall actively and strategically purchase healthcare services on behalf of users in accordance with the needs and provisions of the NHI Act.[81] As I have noted and emphasized before, the legislation holds that the NHI Fund, as a sub-system of the healthcare financing reform, will purchase services from private healthcare providers and include the private sector for the first time. I disagree with this aspect of the legislation. The private healthcare sector must be excluded. To reiterate, the NHI Fund should not be used to purchase services from the private healthcare sector, this will only expand private healthcare sector operations in South

[76] The NHI Bill (2018) establishes the NHI Fund as an autonomous public entity and sets out its powers, functions and governance structures. The NHI Fund is established as an autonomous public entity as contained in the Public Finance Management Act, Schedule 3A.

[77] Draft NHI Bill, 10. In page 12 of the NHI Bill (2018) it states that "user" means a person, and his or her dependents [*sic*], registered as users in terms of section 8(1), and includes a person registered as a beneficiary in terms of section 8(1).

[78] It is possible to produce items (1) to (6) in South Africa. This aspect must speak to the human resource development and youth employment creation strategy.

[79] *Draft National Health Insurance (NHI) Bill*, 34.

[80] Child, 'Doctor exodus feared as NHI proposes bold cure,' 6.

[81] *Draft National Health Insurance (NHI) Bill*, 34. This appears in page 44 of the draft NHI Bill. See also page 17.

Africa and collapse the public sector. Such a system furthers privatization and private interests in a relatively free-market instead of advancing nationalization and preventing the healthcare sector from becoming an avenue of private profiteering (thereby protecting the healthcare economy from free-marketization). The NHI Fund is formed under the assumption that the healthcare work-force will also be engaged in private (non-governmental) employment producing healthcare goods and services and selling these in the market at a profit. In this context, the NHI Fund should focus on healthcare professionals in public service and the funds should be used to improve the healthcare infrastructure, working conditions, and salaries of public servants in the public healthcare service. I emphasise that the private healthcare sector should not be sustained using public funds. The reality of the private healthcare sector is regarded as abstract, unchanging, and super-rigid, but it is concrete. Therefore, if it seeks for public funds then it must be changed (transformed) and be brought into the legal ownership and control of the state (meaning: it must be nationalized).

Currently, the NHI Fund is conceptualized to be a financing mechanism to purchase healthcare as a commodity that is traded in the free market system. Yet, the NHI Fund forms a real starting-point for the implementation of the NHI system; it is an implementation mechanism. But in its current formulation, it runs the risk of being a financial capital formation for capitalist healthcare production and private healthcare sector expansionist interests. In its current formulation, it is designed for the further development and maintenance of commodified private healthcare and the commercial circulation of healthcare products. Furthermore, the NHI Fund should be geared towards ensuring the sustainability of funding for better public healthcare services that are improved and upgraded for delivering healthcare services that are intended for the use, diagnosis, and improvement of the healthcare status of state patients. I reiterate that the NHI Fund needs to be utilised for the improvement of healthcare systems in the public healthcare sector *only*. The two-tiered healthcare system in South Africa should not be kept intact; it should be dismantled and converted into a single tier. If this does not occur, then through the NHI Fund private healthcare establishments may be guaranteed survival, thereby expanded, as I argued earlier. Yet, private healthcare facilities, if nationalised will be at the same time preserved. Therefore, to reemphasize this point, in the South African case the state should use public funds in general, and the NHI Fund in particular, to improve the public healthcare sector and to systematically upgrade its deteriorated conditions.

From my observation, the NHI Fund instead ties the two sectors together. Thus, two healthcare sectors that are contradictory are connected. All hospitals (public or private) that will work

with the NHI Fund must be registered with the NHI Fund so that their quality may be regulated. This is the logic. For healthcare providers or healthcare establishments to be reimbursed by the NHI Fund they must be accredited, and they must submit patient related information to the NHI Fund for recording on the Health Patient Registration System.[82] Patient related information in such a system will involve (1) National identity numbers, (2) Diagnosis and procedure, (3) Detail of treatment, (4) Diagnostic tests ordered, (5) Length of stay of an inpatient in a hospital facility, (6) Facility to which a user is referred, (7) Reasons for non-provision of treatment, and (8) Any other information.[83] Under the subtitle "registration of users" [(Article 5(a) and (b)] the NHI Bill (2018) states that,

> A public healthcare facility accredited by the [NHI Fund] in terms of Section 35 and this Act and identified by the Minister in the Gazette must on behalf of the [NHI Fund] (a) issue a user with a registration number that is also applicable to each of his or her dependents together with physical evidence of his or her registration with the NHI Fund and that of his or her dependents, if any; and (b) maintain and keep up to date a register of all beneficiaries and their dependants.[84]

The NHI Bill (2018) establishes the NHI Fund to be a single strategic purchaser. The NHI Fund is to be the financing mechanism that shall be used to purchase healthcare services from certified and accredited healthcare service providers on behalf of the South African population. The former Minister of Health (Motsoaledi) maintained that,

> [This is where the NHI system comes in. In all these programmes, i.e. the Surge Programme, the Screening Programme, the School Health Programme, the Cancer Programme, the Mental Health Programme and the programme on dealing with complicated pregnancies, we shall make sure, as you might have noticed, that doctors and specialists in the private health sector will get heavily involved.[85]

Neil Kirby (medical lawyer) of Werkmans said that, "in view of the scarcity of doctors, it would not be a good strategy to freeze out those who did not stick to NHI rates."[86] Kirby agrees with the strategy to involve the private healthcare sector. Kirby, in agreement with Motsoaledi,

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[82] *Draft National Health Insurance (NHI) Bill*, 32.

[83] *Draft National Health Insurance (NHI) Bill*, 33.

[84] *Draft National Health Insurance (NHI) Bill*, 17.

[85] Motsoaledi, Debate on the health budget vote – 16, 15.

[86] Neil Kirby, cited by Katherine Child, in an article entitled: 'Doctor exodus feared as NHI proposes bold cure,' *Sunday Times*, 24 June 2018, 6.

maintains that, "The prudence of excluding [private] healthcare providers, in an already strained system starving from a lack of available expertise is highly questionable if not irrational."[87] Yet, the public system is strained and starved due to its interaction with the private sector. The expertise that are available to the public sector have migrated to the private sector. It is Kirby's position that is questionable. Motsoaledi, in this context, is being irrational. Public service providers must meet the criteria of allocation of a skills and expertise mix and appropriate number healthcare professionals without the involvement of the private sector. The NHI Bill (2018) establishes rules to facilitate purchasing of healthcare services and healthcare products and determines the payment rate. Payment includes funds, allowances, reimbursements, loans, and repayments. In the case of specialists and hospital services (in the private and public healthcare sectors), payments will be all-inclusive and performance-based. Motsoaledi's focus should have been on the public system and his position when it comes to the private healthcare sector should have been negation (and nationalisation).

The NHI Fund will monitor the registration, license or accreditation status of healthcare providers. The NHI Bill (2018) outlines the process with regards to registration that a person who is eligible must register at a public or private healthcare institution. I have emphasized that there is an essential connection between the private and public health sectors that is contradictory. Though the two sectors exist in one healthcare system, they have opposing tendencies. Ron Derby says that South Africa has produced some of the best training systems in the world for both doctors and nurses, but highly skilled and knowledgeable people have drifted to the private healthcare sector and overseas markets.[88] Derby is correct, this "migration" and "drift" is due to the fact that contradiction is the root of both the identity of the two sectors and their relationship in their concurrent development. Johan Serfontein (of Health Man, a consultancy that represents doctors in private practice) said that, "'[There] is an underlying assumption that specialists will be employed by private hospitals.' This is currently not the case as the law ensures [that] doctors work for themselves but are based at private hospitals. 'A survey done by the South African Private Practitioners Forum showed that 55% of specialists do not want to be employed by hospitals. [Therefore] one can safely assume those will be the ones considering emigration.'"[89] Yet, this drift is exactly what the NHI system should seek to change. The NHI Fund must deal decisively with the assumption that specialists

[87] Child, 'Doctor exodus feared as NHI proposes bold cure,' 6.

[88] Derby, 'Time for our health minister to bridge the trust deficit,' 2.

[89] Child, 'Doctor exodus feared as NHI proposes bold cure,' 6.

will be employed by private hospitals, seeing that this is currently not the case and doctors work for themselves, then the NHI Fund should ensure that conditions in the public healthcare system are conducive for doctors to be based at public hospitals. It is important not to overlook this point. I insist, that as two concrete sectors, the private healthcare and public healthcare sectors are not complimentary but are contradictory. Between them lies a tension and a potential for conflict, if not conflict. Yet, the NHI Bill (2018) states that,

> A person who is eligible to [healthcare services] as provided for in [Section 7 of this Act] must register as a user with the [NHI Fund] at a public or private [healthcare establishment or healthcare facility] that is accredited in terms of [Section 36 of this Act] and identified by the Minister in the Gazette and must at the same time register his or her dependants with the Fund.[90]

Exactly what should change and be omitted in the above clause quoted above should be the term private. What then that will achieve is that registration would occur in public healthcare systems only. There must be a clear demarcation. If a person is registered with the NHI Fund, the NHI Fund shall determine what services that person may have. Furthermore, the NHI Bill (2018) states that (patient) data will be compiled and stored by an independent data company to ensure that data is accurate and equally accessible to the national Department of Health and the NHI Fund.[91] This also should change. Patient data cannot be held in private hands. Data regarding the NHI Fund must be stored by the state *only*; as comprehensive healthcare services shall be purchased by the NHI Fund on behalf of the person. Issues around cost coverage must speak to the public sector *only*. The NHI Fund then must list public institutions *only* and seek to improve and accredit them as service providers from which it will purchase services from. This is possible. Public healthcare service providers must provide the minimum required range of personal healthcare services. A universal system should not be interpreted vaguely to mean that patients can go anywhere, but an interpretation of universal coverage should be contextualized to mean in the public system *only*.

The former Minister of Health (Motsoaledi) suggests that public patients may be treated at private hospitals, which would increase the use of private hospitals that are not always full.[92] This view supports private sector profit interests. Private hospitals not always full because they

[90] *Draft National Health Insurance (NHI) Bill*, 16.

[91] *Draft National Health Insurance (NHI) Bill*, 32.

[92] Child, 'High costs mar medical bill,' 4.

are expensive, they have designed for a minority. Motsoaledi should have concentrated on public hospitals, that they are always full; therefore, new public hospitals need to be built. But Motsoaledi oscillated between two systems, yet in the healthcare system the private healthcare sector and the public healthcare sector are opposing forces. There is a dialectical contradiction between them. It is a concrete contradiction that takes the form of a conjunction of incompatible aspects. It is a contradiction that exists in contracting private healthcare institutions for public patients, who in their majority are to be treated at private hospitals according to Motsoaledi's logic. Such a logic and logistic will lead to the expansion of the private healthcare sector and a conflict between the public healthcare sector and the private healthcare sector which are opposing forces. According to Barry Price (Insight Actuaries and Consultants) it is likely to be difficult to determine a fair price for both sides.[93] Here Price is correct. He understands the South African healthcare system to be operating within the ideological framework of capitalism.

The South African Society of Anaesthesiologists (Sasa, which represents 90% of the country's anaesthetists) released figures from its own research which showed that 482 of the country's 1379 medical specialists would either leave the profession or emigrate should the NHI system be enacted.[94] However, accredited (private or public) primary healthcare providers will be funded on a risk adjusted capitation basis. Pillay states that, "State-regulated fees on what doctors can charge for their services may leave some considering emigration if the lower tariffs will leave them bankrupt, and this will in turn leave an already overburdened healthcare sector even weaker."[95] The NHI Fund, if framed correctly and coherently can prevent this phenomenon of migrations. Sasa maintains that 79% of private sector and 59% of public sector anaesthetists believe the introduction of the NHI system would be detrimental to their profession.[96] This is possibly due to the threat that it will control prices. However, my position is that the outcome of the concrete contradiction between the private healthcare sector and the public healthcare sector in the South African healthcare economy must lead to the eventual dissolution of the private healthcare sector – a negation, a dialectical negation and a concrete negation – the result should be one healthcare system and one price system. I have no problem with the NHI Fund financing healthcare as an essential service or purchasing healthcare related

[93] Tamar Kahn, 'Disputed health bills head for heated debate,' *Business Day*, 22 June 2016, 1.

[94] Koko, 'Medical specialists threaten to emigrate over NHI,' 1.

[95] Kailene Pillay, 'Several imponderables may bedevil NHI,' *The Star*, Wednesday, 27 June 2018, 4

[96] Koko, 'Medical specialists threaten to emigrate over NHI,' 1.

products for healthcare users; what I have a problem with is the NHI Fund sending its money into the private healthcare sector. Hence, I am arguing for the negation of the private healthcare sector in the operation and in the function of the NHI Fund. What I would rather see, I reiterate, is the NHI Fund being used to improve the dysfunctional public healthcare sector, and a better public healthcare service that will be at a higher level of quality beyond that of the current private healthcare sector. In this way, the NHI Fund will also present an opportunity to ensure that healthcare inputs are manufactured by the state and to procure healthcare products from state-owned healthcare companies.

5.6 Interactions between the two sectors in the NHI system

The former Minister of Health (Motsoaledi) has suggested that through the NHI Fund healthcare prices shall be regulated by government (through a uniform tariff). The private healthcare sector has opposed this idea. But the government shall procure/purchase healthcare through the NHI Fund as a purchasing mechanism. There remains a deadlock. To resolve the impasse, the NHI Bill (2018) holds that the minister will appoint a Board. The Board will govern the NHI Fund and the Board shall be accountable to parliament. The public will appoint people and make nominations of people who are eligible to serve in the Board. These people shall be interviewed by parliament. Parliament shall make recommendations. The minister shall make the appointments. The functions of the Board must comply with South African corporate governance. There is one rider, in the Board there must be one representative from organized labour and one representative from business because the private sector also offers healthcare services and seeing that the NHI Fund will procure services from them. Elsabé Klinck (healthcare consultant) said that this could offer opportunities to the private sector, but it was not yet clear how private-sector hospitals and administrators could provide services to the state.[97]

According to the NHI Bill (2018), the Minister of Health shall establish an Office of Health Products Procurement that is accountable to the Board of the NHI Fund. This office will annually or regularly review the Formulary (comprised of the Essential Medicines List and Essential Equipment List) and shall be located at the NHI's national offices (for centralised facilitation and coordination, monitoring and advice to the Board). Notably, the language of 'healthcare at "*no cost*" to the patient' emerges in the NHI Bill (2018) instead of '"*free*" healthcare for all.' Under the subtitle "cost coverage" [Article 11(1)] a person who is registered

[97] Child, 'High costs mar medical bill,' 4.

as a beneficiary of the NHI Fund will receive such services purchased on his or her behalf by the NHI Fund from certified and accredited healthcare providers at *no cost.* The NHI Fund, proposed to be the largest funder in the country, could mean more business for the private healthcare sector in general, and private doctors including private hospital groups in particular.[98] The former Minister of Health (Motsoaledi) did not rule out the idea of using a private administrator that currently manages medical aid funds to run the NHI Fund.[99] The former Minister of Health (Motsoaledi) pointed out that,

> [The essence of the NHI system] is to make sure that both the public health facilities and skills, and the private sector facilities and skills are available to all the citizens of our country. This is what we are starting to implement in these NHI projects. Making sure that some of our programmes are undertaken by the private sector. [This] will contribute heavily in lessening our burden. For instance, we shall decant 50 000 patients to 250 private GPs…The [private] GPs will be paid their service fees.[100]

Motsoaledi's idealist position that NHI programmes that are undertaken by the private sector will contribute in lessening the burden in the public healthcare sector is flawed and lacks a material basis. Observers are particularly interested in what the NHI Act will have to say about private sector pricing and whether it will recommend establishing a mechanism for price control.[101] In view of Motsoaledi's position in the above quotation and in the introduction of the NHI system there will be price regulation and a cap on what doctors can charge. However, neoliberals argue for less regulation by government to allow business to flourish and control its own prices. According to legal and medical experts many doctors would reject the cap on what they can charge for consultations and surgeries.[102] According to Pillay, Henru Krüger operations manager and legal expert at the Alliance of South African Independent Practitioners' Association (Asaipa) told the Rapport that doctors, and other medical

[98] Child, 'High costs mar medical bill,' 4. Adrian Gore has also noticed this point.

[99] Child, 'High costs mar medical bill,' 4. Gore, seeing that he currently manages Discovery Health as a medical aid fund, has also been considered in certain sections in the healthcare industry to be the appropriate person to administrate and run the NHI Fund. This concept of Discovery Health administrating the NHI Fund should not be permitted. Discovery has set up a bank. I presume that one of Discovery Bank's targets is to bank and administrate government funds. This is a problem.

[100] Motsoaledi, Debate on the health budget vote – 16, 15.

[101] *Business Day*, 11 June 2018, 1.

[102] Katherine Child, 'Doctor exodus feared as NHI proposes bold cure,' *Sunday Times*, 24 June 2018, 6.

practitioners, would turn to the courts should they be forced to work at fixed rates.[103] Malan, quoted earlier, alluded to this.

Some analysts warned that state-regulated fees would drive private doctors to emigrate, leaving the health sector worse off than it is now.[104] But the public healthcare sector is already worse off and is currently not dependent on private healthcare professionals, but healthcare practitioners in public service. Michelle David holds that doctors were likely to challenge [the NHI system] in the courts, as they had challenged price control before.[105] David's analysis is correct. Neoliberals recognize that not all efforts to cooperate will yield them good results. Yet, in recognizing the co-existence of the private healthcare sector and the public healthcare sector concurrently operating in one system, there needs to be an equal recognition that there are neoliberal forces opposing and negating the public healthcare system, which leads to the dysfunction and collapse of the public healthcare sector. However, the dialectical approach always sees in the result of contradiction a determinate negation of the private healthcare sector and a unified healthcare system in a single-tier immediately rising.

An emerging property in the current healthcare system, as a result of the introduction of the two bills, is that the private healthcare system may turn to the NHI Fund in order to survive. Hence, the private healthcare system cannot be abstracted from its concrete context. Otherwise it will collapse if it is to depend on medical aid schemes only. It is embedded in the current healthcare system and essentially related to the public healthcare sector in its interactions with it. One view to consider is that when the private healthcare system can no longer survive because it depends fully on medical aid schemes as private purchasers of private healthcare, then the state may nationalise it before it can receive any money from the NHI Fund. At this stage, it would be incorrect to interpret the NHI system as a socialist system seeing that its objective is to deliver free healthcare for all. Within a socialist framework, the option of nationalization (state ownership) would preserve and maintain all healthcare facilities as the means of healthcare production by bringing them into state ownership and control. Therefore, it is important for the state to own and control all the healthcare facilities and to control state funds, by putting an end to the two-tiered healthcare system and ultimately to privatization of healthcare in South Africa. The challenge presented in the NHI policy and legislation is that a person who is not entitled to healthcare services purchased by the NHI Fund in terms of the

[103] Kailene Pillay, 'Several imponderables may bedevil the NHI,' *The Star*, Wednesday, 24 June 2018, 4.

[104] Child, 'Doctor exodus feared as NHI proposes bold cure,' 6.

[105] Child, 'Doctor exodus feared as NHI proposes bold cure,' 6.

provisions of this legislation must pay for the services rendered directly or through a voluntary medical insurance scheme or any other private medical insurance scheme. Relatedly, the private healthcare sector is the negative (expensive, unaffordable) requiring a private medical insurance scheme to ensure access. Negative as it is, it has emerged as a result of a dialectic. Thus, it is at the same time potentially the positive. The private healthcare sector contains what it results from, absorbed into itself and made part of its own nature. Therefore, in the context in which it seeks financing from the NHI Fund, the conglomerate private healthcare sector must be nationalised and brought into the ownership and control of the state before the state can consider funding it.

5.7 Conclusion

Conglomerate private healthcare interests have succeeded to shape the NHI policy and legislation in their favour, especially the NHI Fund as a financing and implementing mechanism of the NHI system. Having discussed the NHI Green Paper (2011), NHI White Paper (2015 – 2017), NHI Bill (2018), and Medical Schemes Amendment Bill (2018), I come to the conclusion that the NHI system in its current framework is unlikely to contribute to the transformation of the public healthcare system. Furthermore, I argued that healthcare should not be treated as a commodity. Rather, it must be de-commodified and must not be given exchange-value and then traded in the free-market system. Instead, it must be de-commercialized and offered for free by the state only in a single-tiered healthcare economy where the private healthcare sector is negated.

Moreover, the private and public healthcare sectors are not static but have a dynamic and complex relationship that is effectively contradictory and in opposition. I defended a position that healthcare is a use-value, that it should be secured for all, and offered to all equally and paid for by the state so that it is free for all, and all healthcare facilities are made free and accessible in one healthcare system. I emphasized that privatization should not be permitted in the healthcare sector. I also reiterated that the private healthcare sector must be negated, and the two-tiered system must be dismantled. The private healthcare system must cease to exist. Everyone should have access to quality healthcare for free in a single system. I support the NHI system, however, as a public sector-led system that operates in the public sector *only*. The public healthcare system must be improved, and the private healthcare sector must be brought into the legal ownership of the state if it is to receive any funds from the NHI Fund. In the next chapter, I compare competing ideologies and meta-theories: neoliberalism and socialism.

These ideological systems (paradigms) underpin the two healthcare sectors. I show that these ideological systems compete and do not complement each other. I then draw conclusions from their explanatory powers that are relevant to the discourse on NHI system.

Chapter 6

An ideological contestation of the NHI system within a two-tiered system

6.1 Introduction

The previous chapter offered a discussion of the National Health Insurance (NHI) policy and legislation in the context of the NHI Green Paper (2011), NHI White Paper (2015, 2017), NHI Bill (2018) and the Medical Schemes Amendment Bill (2018). The purpose of the discussion was to raise the question: can the NHI system and legislation bring about the stated goal? I argued that it cannot because of the contradictions – in Marxist terms – between treating healthcare as a *(i)* use-value and as a *(ii)* commodity.

In this chapter, *(a)* I compare competing ideologies: neoliberalism (as an ideological paradigm for privatisation, private ownership and control) and socialism (as an ideological paradigm for nationalization, state ownership and control). These are ideological systems (paradigms/meta-theories) that underpin the two healthcare sectors. I show that these ideological systems compete and do not complement each other; *(b)* I show how the two ideologies relate to the two healthcare sectors (and to the issue of a one-tier or two-tier system); and *(c)* I address the ultimate question of whether the proposed NHI system is likely to provide a just/equitable healthcare system. I consider the two competing ideologies in relation to the ongoing discourse and to the latest proposals on the NHI system. I use dialectical materialism as a framework to analyze the two healthcare sectors (private and public) as complex systems.

I also analyze the tensions and differences amongst the various ideologies and reflect on their status in healthcare discourse. The focus is on the philosophical analysis of the ideological systems that underpin the NHI policy and legislation and to determine whether there shall be *free* healthcare "at the point of care" for all in a *unified* system upon the implementation of the NHI system. The chapter does not focus on the healthcare system (proper), but ideological systems. In my analysis, there is an ideological contradiction within the NHI policy/legislation. By contradiction, I mean a malfunctioning that arises from the economic relations that typify the NHI system as a financing system. This contradiction is potentially a very powerful source of systemic change. However, such a contradiction also locates itself within neoliberal capitalism.

6.2 Neoliberal ideology and the apparent unity of private and public healthcare sectors

The first transition in South Africa was evolutionary precisely because it involved dismantling the apartheid state and building a democratic state, though the capitalist components of the apartheid state remained intact as the unending instrument of white racist minority rule.[1] In the democratic setting, capitalism in the South African healthcare system has become prescribed conduct. It is universalized and remains exploitative given universalized validity by its ideologues. The socialist critique of capitalism in healthcare is that the South African healthcare system cannot be governed by racialized profiteering and by a monopolized conglomerate private healthcare system. Such a monopoly exists in an unequal society in which economic power over the healthcare economy is outside public ownership and control. However, contemporary South African society converges around neoliberalism and South Africa's historical model of racialized capitalist accumulation.

Neoliberalism underpins the private healthcare sector. The term neoliberalism suggests a system of principles that are based on classical liberal ideas. But, unlike classical liberalism, neoliberalism recognizes that political agencies must frequently act as financiers, supervisors and regulators of markets and marketization.[2] Moreover, neoliberalism is an ideology of political economic practices proposing that human wellbeing can best be advanced by the maximization of entrepreneurial freedoms within an institutional framework characterized by private property rights, individual liberty, unencumbered markets, and free trade.[3] By contrast, dialectical materialism is the ideological basis for a socialist argument. Socialism underpins the public healthcare sector. Dialectical materialism is an alternative ideological framework that brings into focus the complex interactions that occur in a neoliberal system. Dialectical materialism discloses the contradictions in the neoliberal argument and overcomes it.

The term dialectic comes from the Greek word *διαλεγό* (*dialego*) meaning to discourse, to debate. The dialectical process whereby healthcare, and the relationship between the public

[1] Early in the 1990s South Africa hosted an encounter between two logics – the logic of the National Democratic Revolution (NDR) and the logic of Constitutional democracy – whose discordant relationship remains unresolved. The NDR seeks a people's power. Constitutional democracy, a product of legal and moral philosophy, seeks to constrain people's power. These two logics differ in their conception of the demos: the NDR sees it as collective, ideologically socialist; on the other hand, Constitutional democracy is individuated, underpinned by neoliberalism.

[2] Michael. C. Howard and John. E. King, *The rise of neo-liberalism in advanced capitalist economies: a materialistic analysis,* (London: Palgrave, 2008), 40.

[3] David Harvey, 'Neoliberalism as creative destruction,' *Geografiska Annaler*, Series B, Human Geography, Vol. 88, No. 2, Geography and Power, the Power of Geography (Wiley: Swedish Society for Anthropology and Geography, 2006), 145.

healthcare sector (socialist, state owned) and the private healthcare sector (capitalist, privately owned) develops, works in a systemic way. Complex systems characterize the two South African healthcare sectors which have evolved historically. The current system of healthcare financing in South Africa is two-tiered (two opposites) and is based on socioeconomic status, and social location, thereby continuing to perpetuate poor national healthcare outcomes and inequalities within a complex network of various interactions in a two-tiered healthcare system. Consequently, the presence of the two-tiered system is both a structural and ideological issue.[4] Such a system is also based on race and class determinants which perpetuate racialized social and economic inequalities.[5]

In the South African healthcare economy, a large proportion of funding is allocated through medical schemes that provide cover to private patients and benefits those who are employed and are subsidized by their employers (both the public/state and the private sector). According to the NHI Green Paper (2011) the other portion is "funded through the fiscus and is mainly for public sector users. This means that those with medical scheme cover have a choice of providers operating in the private sector which is not extended to the rest of the population."[6] Accordingly, in South Africa the economic policies of capital and the state, along with the extreme concentration of economic power within a handful of white-owned conglomerates, are the starting point of healthcare capital.[7] Value theory aims to reproduce at increasing levels of complexity the key economic relations, processes and structures prevailing in capitalist society.[8] However, the major weakness which has emerged in the practice of socialism in South African society and in the healthcare economy is a result of a distortion of socialism and a misapplication of communism. Communism is the negation of private property. On the other hand, socialism shifts an economy from one economic reality to another.

The NHI policy and legislation seems to take a socialist approach to universal healthcare. But

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[4] Richard Downie and Sahil Angelo, 'Counting the Cost of South Africa's Health Burden,' *Report of the CSIS Global Health Policy Center,* (Center for Strategic and International Studies, July 2015), 13. See: https://www.researchgate.net/publication/280718376

[5] Shan Naidoo, 'The South African national health insurance: a revolution in health-care delivery!' *Journal of Public Health*, Vol. 34, No. 1, (Oxford: Oxford University Press, 2012), 149–150. Downloaded from https://academic.oup.com/jpubhealth/article-abstract/34/1/149/1557418 on 27 February 2019.

[6] *National Health Insurance in South Africa: Policy paper* (Department of Health: Republic of South Africa, 2011), 4.

[7] Alec Erwin, 'South Africa's post-apartheid economy, planning for prosperity,' *South African Labour Bulletin*, Vol. 14, No.6 (February 1990), 43.

[8] Ben Fine and Alfredo Saad-Filho, *Marx's capital* (6th edition), (London: Pluto Press, 2016), 13.

its weakness is that it appears to be socialist by aiming to offer free quality healthcare to all in the public healthcare system. Yet, in reality it is capitalist in that it also facilitates capital accumulation within the private healthcare system by seeking to involve the private healthcare sector in offering free healthcare to all in the population. It is in this sense that it contradicts itself. This contradiction is an ideological one. It avoids being communist in that it seeks to involve the private healthcare sector instead of negating it. The incorporation of both sectors in offering free healthcare involves the following distinctions: a mixture of two conceptual categories – firstly, the public healthcare sector, secondly, the private healthcare sector, wherein healthcare is a commodity that is presented as a complex of two things – use-value and exchange-value. Here the ideological contradiction manifests itself in very concrete terms.

The NHI Green Paper (2011) holds that, "A larger part of the financial and human resources for health is located in the private health sector serving a minority of the population. Medical schemes are the major purchasers of services in the private sector."[9] This leads to a skewed distribution of key healthcare professionals in favour of the private sector with more professionals per patient in the private sector than the public sector. Therefore, the claim in the NHI Green Paper (2011) is that the NHI will ensure that everyone has access to a defined comprehensive package of healthcare services for free.[10] To support this claim, the NHI Green Paper (2011) maintains that, "The covered healthcare services will be provided through appropriately accredited and contracted *public and private providers*."[11] In this instance, the unity of the "*public and private providers*" first appears to be coherent. Thus, it also appears as if it obeys the dialectical law of the unity of opposites. In reality, it does not. The "private" and the "public" dichotomy are two complex elements of an unequal two-tiered system. Moreover, within the public healthcare sector there is an urban, exurban, and rural divide which has a race and class dynamic. In this divide, the public healthcare service as a practical government activity, answers to a practical need; it has a use-value. Its utility gives it use-value. In the private healthcare sector healthcare is a commodity; it has exchange-value. Hence, private medical practitioners are also reluctant to serve the majority in rural communities. A minority of the population pay to use a first-rate urban-based private healthcare system while the majority must find their way through an underfunded, overcrowded public healthcare

[9] *National Health Insurance in South Africa: Policy paper* (Department of Health: Republic of South Africa, 2011), 4.

[10] *National Health Insurance in South Africa: Policy paper*, 16.

[11] *National Health Insurance in South Africa: Policy paper*, 16.

system, especially in the townships and rural areas.[12] The majority are black in general and African in particular. In such a two-tiered, racialized and unequal healthcare system there is interdependence in such a way that a change in the one system affects the other system in a predictable manner.

Complexity emerges as a result of the patterns of interaction between the two systems. Accordingly, the two healthcare systems (private/public) are distinct in themselves yet related to the rest of the healthcare system. It is a complex structure. The distinctions are that one sector is private, and the other sector is public, yet they are related. In other words, the particular (private healthcare) is in the general (public healthcare), and the general (public healthcare) is in the particular (private healthcare). But, the growth of the private healthcare sector in South Africa has been skewed towards the urban and suburban areas, the previously white areas, with an unequal distribution of resources for public and private healthcare system users. This complex unequal distribution of resources also has race and class dimensions. However, the private healthcare sector is characteristic of the public healthcare sector's general properties – they are both offering healthcare, though at varying levels of quality, affordability, and accessibility.

6.3 Capitalism in the healthcare system and an ideological tension

Deep disparities are found in the healthcare services available to blacks and whites, rural and urban dwellers, those on private medical aid schemes and those who have to make use of public healthcare provision.[13] Downie and Angelo affirm that quality healthcare services shall be *provided for free* at the point of care by both private and public healthcare providers, paid for by a government fund – the NHI Fund. [14] The cost of its administration is estimated at around R10.9 billion.[15] As a government fund, the NHI Fund is a form of financial capital. It is effectively money – a form in which capital appears. It also concerns the circulation of money – to purchase healthcare as a commodity, in a cycle of healthcare reproduction and capital accumulation.[16] In this sense, the NHI Fund is the starting-point. In its current formulation, it is a financial capital formation for capitalist healthcare production and expansion. It is designed

[12] Downie and Angelo, 'Counting the Cost of South Africa's Health Burden,' 13.

[13] Karl von Holdt, Critical engagement in fields of power: Cycles of sociological activism in post-apartheid South Africa, *Current Sociology Monograph,* Vol. 62(2), (London: Sage, 2014), 183.

[14] Downie and Angelo, 'Counting the Cost of South Africa's Health Burden,' 13.

[15] Shivani Ramjee and Heather McLeod, 'Private Sector Perspectives on National Health Insurance,' *SAHR* (2010), 188.

[16] James D. White, *Karl Marx and the intellectual origins of dialectical materialism* (London: Macmillan Press, 1996), 162.

for the further development and maintenance of healthcare as a commodity and the circulation of healthcare products as commodities.[17] The coupling of private and public healthcare providers in the provision of free healthcare for all is notable. The neoliberal argument does not appear obvious. Drawing directly from free market ideas and the tradition of neoclassical economic liberalism, neoliberals argue that the relentless pursuit of profit in the healthcare system would create a growing economy as well as a free and equitable society. Thus, the NHI Green Paper (2011) insists that, "The main responsibility of the National Health Insurance Fund will be to pool funds and use these funds to purchase health services on behalf of the entire population from contracted public and private healthcare providers."[18]

To contract the private healthcare sector is a feature of capitalism and capital accumulation and remains the ideological problem in the NHI policy and legislation. Another crucial feature of capitalism in the healthcare system is that it is a highly developed and complex system of healthcare commodity production. Use-values become a reality only by use or consumption; exchange-values constitute the substance of all wealth, whatever maybe the social form of that wealth.[19] As exchange-values, commodities are, above all, of different qualities, they consequently do not contain an atom of use-value.[20] Use-value distinguishes itself from exchange-value by its usefulness, which cannot be quantified in general, from the ability to exchange with other commodities which can be quantified.[21] Use-values and the labour of living individuals are qualitative and heterogeneous.[22] Exchange-value and social labour are quantitative. This quality and quantity are connected yet distinct and interact with one another. Exchange-value is measured quantitatively: its specific measure is the currency.[23] Hence, the NHI Fund (a subsystem) is a strategic purchaser of healthcare as a commodity in the NHI system (which is the main system of interest) in offering healthcare as a use-value; herein lies the contradiction.

As a subsystem, the NHI Fund is a mechanism to purchase healthcare as a commodity. Therefore, it should be seen not as an independent element, but as having a particular type of contradictory relation in the system that of purchasing healthcare in the private healthcare

[17] Modified from White, *Karl Marx and the intellectual origins of dialectical materialism*, 162.

[18] *National Health Insurance in South Africa: Policy paper*, 16.

[19] David McLellan, *Karl Marx: Selected writings* (New York: Oxford University Press, 2000), 421.

[20] McLellan, Karl Marx: Selected writings, 423.

[21] Fine and Saad-Filho, *Marx's Capital*, 15.

[22] Henri Lefebvre, *Dialectical Materialism*, (London: University of Minnesota Press, 2009), 78.

[23] Lefebvre, *Dialectical Materialism*, 78

sector. The ideological contradiction lies in the fact that the NHI system is a form of state intervention in the healthcare system. It appears to be based on a socialist ideology. Hence, free healthcare for all. Yet, according to neoliberal ideology, state intervention (once created) in market-based systems must be kept to a bare minimum. The capitalist argument is that the state cannot possibly possess enough information to second-guess market prices and powerful interests will inevitably distort and bias state interventions, particularly in democracies, for their own benefit.[24] Unfortunately, the case with the NHI system is that the reality of capitalism and the appearance of socialism find themselves at loggerheads. There is an ideological battle in the system. The main position of the NHI policy and legislation is that the private healthcare sector must benefit from the NHI Fund and that the private healthcare conglomerates must be involved in offering free healthcare services to the entire population, irrespective of racial inequalities, income inequalities, social status, or inequalities of location and property.

In the shift from the NHI Green Paper (2011) to the NHI White Paper (2015) the neoliberal and capitalist argument is kept intact. Thus, the NHI White Paper (2015) affirms that, "The healthcare services will be accessed at the appropriate level of care and will be delivered through certified and accredited public and private providers using the NHI Card."[25] Notice again the coupling of the two sectors and the co-option of the private healthcare sector in free healthcare provision for all. The claim is that South Africans will be able to access personal healthcare services covered by the NHI system closest to where they reside using the NHI card. Yet, private healthcare institutions and facilities are seldom closest to where the majority poor and working-class reside. Thus, to understand the NHI system, it needs to be taken apart; but to reduce the private sector and the public sector to separate individual elements as the policy has done is mechanistic and reductionist. There is a challenge with such reductionism. The healthcare system of South Africa is much more complex. This complexity informs the relationship between the two healthcare sectors. Therefore, any analysis needs a complex systems and dialectical materialist approach that looks at such complexity. For example, to illustrate the complexity, according to Gwen Ramokgopa (MEC Gauteng Department of Health), the Gauteng Department of Health has already made progress in the following:

> *(i)* Advanced registration of the population for [the NHI system] with over 7 million citizens already registered; *(ii)* Improvement of health facilities in the ideal clinic

[24] Harvey, 'Neoliberalism as creative destruction,' 23.

[25] *National Health Insurance Policy: Towards Universal health Coverage*, (Department of Health: Republic of South Africa 2015), 1.

> project, which is aimed at improving health service provision; *(iv)* [Gauteng province taking] lessons from [the "Life Esidimeni" saga]; (v) Stakeholders [working] together [to] design a [NHI system] that will work for all South Africans and meet the objectives of access to healthcare regardless of one's social status.[26]

In view of the above information, the NHI system is being implemented. In Gauteng 7 million citizens are already registered. Accordingly, the NHI White Paper (2015) holds that, "South Africans that have been registered with the NHI system will be issued with an NHI card linked to the Department of Home Affairs' smart identification system. The information on the NHI card will be encrypted and will be utilized to access services at different levels of the health system."[27] The private healthcare sector is included in the implementation process. This is a triumph of the principal architects of the neoliberal order and masters of the private economy, mainly huge corporations (conglomerates) that control much of the international economy and have the means to dominate policy formulation as well as the structuring of thought and opinion.[28] Neoliberalism is a doctrine and a related social practice.[29] It is a doctrine in that all economic and social problems have a market solution, with the corollary that state failure is typically worse than market failure.[30] The doctrinal system is also known as the "Washington Consensus," which (accurately) suggests a global order.[31] However, neoliberalism is not, by definition, the same thing as globalization, though the two phenomena overlap.[32] Post-apartheid South Africa, especially in the healthcare system, quickly adopted the neoliberal frame.[33] Contemporary democratic South Africa has consolidated it.

In the neoliberal ideological frame, the private healthcare sector and private hospitals can be distinguished from public sector hospitals. But, private sector hospitals/clinics can be used to represent the generality of hospitals. This is precisely because in the NHI system the conglomerate private hospitals have been identified as simply hospitals – from which to register

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[26] *Presidential Health Summit 2018: Strengthening the South African health system towards an integrated and unified health system* (Presidency: Republic of South Africa, 2018), 18. The Summit was held at Birchwood Conference Centre, Johannesburg, 19-20 October 2018.

[27] *National Health Insurance Policy: Towards Universal health Coverage*, 25.

[28] Noam Chomsky, *Profit Over People: Neoliberalism and Global Order,* (New York, Seven Stories Press, 1998) 20.

[29] Howard and King, 'The rise of neo-liberalism in advanced capitalist economies,' 40.

[30] Howard and King, 'The rise of neo-liberalism in advanced capitalist economies,' 40.

[31] Chomsky, *Profit Over People: Neoliberalism and Global Order,* 19.

[32] Howard and King, 'The rise of neo-liberalism in advanced capitalist economies,' 40.

[33] Harvey, 'Neoliberalism as creative destruction,' 24.

in order to be on the NHI system. But the healthcare system must be studied in its particular character (which includes the conglomerate private healthcare sector) as well as its general character (which includes the public healthcare sector) in order to be understood. Thus, the two-tiered healthcare system has its own particular laws which brought it into being. In an array of market-oriented principles, the basic rules, in brief, are: liberalize trade and finance, let markets set the price (get prices right), end inflation (macroeconomic stability), and privatize.[34] Naidoo says that, "In essence the objective of the NHI is to provide improved access to quality health services for all South Africans."[35] This is true. Hence, the NHI White Paper (2015) reiterates that, "There will be contracting of accredited private sector providers at higher levels of care such as private hospitals and specialists. During this phase, there will be mobilization of additional revenue for the NHI through the introduction of mandatory prepayment from those who are eligible."[36] This reality needs to be examined ontologically. The public hospitals are experiencing poor clinical outcomes and higher levels of morbidity and patient mortality. Von Holdt maintains that,

> In the context of the democratic transition, public hospitals [have become] increasingly stressed institutions. [There has been a] redirection of resources to primary healthcare and to the poorer provinces, within a conservative fiscal framework, [this] meant that many hospitals were subjected to diminishing budgets. The pressures for transformation – deracializing access to the health system, redistributing resources, integrating the various health departments including under-resourced and dysfunctional departments for blacks, and deracializing management structures – [has] led to the loss of technical skills, the weakening of management systems and the breakdown of managerial authority.[37]

In public hospitals patient care is undermined by the deep dysfunctionalities of the institutions. However, there is a recognition in the NHI White Paper (2015) that, "[private] hospital prices in South Africa are expensive relative to the country's wealth and they continuously increase above the rate of inflation. In addition, the private hospitals are least affordable…even for individuals of higher levels of income."[38] In this reality, from a (systems) ontological

[34] Chomsky, *Profit Over People: Neoliberalism and Global Order,* 20.

[35] Naidoo, 'The South African national health insurance: a revolution in health-care delivery!' 150.

[36] *National Health Insurance Policy: Towards Universal health Coverage*, 4.

[37] Von Holdt, Critical engagement in fields of power: Cycles of sociological activism in post-apartheid South Africa, 183.

[38] *National Health Insurance Policy: Towards Universal health Coverage*, 13.

perspective there are abstract relations in such a complex organization of the healthcare system. Ramjee and McLeod assert that,

> It is widely acknowledged that there is a human resource shortage in the public sector, that there is a large number of vacant posts and that there is insufficient training of nurses occurring due to the closure of nursing colleges. Poor working conditions in the public sector relate inter alia to the lack of equipment, the unavailability of drugs, the prevalence of HIV and the attitudes of co-workers. Emigration of health workers has also had a significant impact.[39]

Notably, in the relations between the public and the private healthcare sectors there is a migration of public healthcare professionals to the private sector. This migration is governed by deterministic laws and this contributes to the collapse of the public sector. This is the implication of co-opting the private healthcare sector in offering free healthcare for all. It is an *emergent* property. The flow of healthcare professionals away from the public sector will be amplified to have a negative effect on the public healthcare sector. The positive effect for the architects of the neoliberal order and masters of the private economy shall be the expansion of the private healthcare sector. But some of the causal chains shall feed back into the conditions that started the chain, giving the healthcare system nonlinearities. Hence, the claim of the NHI policy is that a range of healthcare professionals working in the private sector will be engaged through innovative contractual arrangements to contribute to addressing the human resources gap in the public healthcare sector. The solution becomes a neoliberal one. Moreover, the NHI White Paper (2015) maintains that,

> Preliminary estimates indicate that the contribution by government…in 2015 is well-in-excess of R20 billion annually and these funds are mostly spent within the private health sector. This creates a fiscal problem for government as public funds are used to [subsidize] state employees to meet the rising costs of healthcare in the private sector.[40]

The relationship between two complex healthcare systems (one public and the other private) and their economic environment or socioeconomic context is in itself a complex problem. This is shown in the contribution by government that funds are mostly spent within the private healthcare sector. The projected cost of the NHI system in 2025 is estimated to be R376 billion

[39] Shivani and McLeod, 'Private Sector Perspectives on National Health Insurance,' 185.

[40] *National Health Insurance Policy: Towards Universal health Coverage*, 18.

(in 2010 terms).[41] Therefore, involving the private healthcare sector creates a fiscal problem for the government, as public funds which could be invested in the improvement and the benefit of the public healthcare sector *only* shall be used to pay for healthcare in the private sector. In the 2010/11 fiscal year, 50.4 percent of government health expenditure occurred in a private sector that is exclusively used by only 16 percent of the population.[42] The assumption is that the NHI system will prevent cost escalation. To ensure equitable access to medicines and related pharmaceutical products, the NHI system will also accredit and contract with private retail pharmacies on behalf of NHI patients. The NHI Fund will then reimburse the cost of the subsidized drugs and other healthcare products as well as pay a capitated administration fee to the retail pharmacies.[43] The argument to support this claim is that as people make greater use of healthcare services under the NHI system, their expenditure on private healthcare services would decrease. This may not be the case. But, personal (out-of-pocket) healthcare expenditure may decrease amongst individuals that could afford personal payment for private healthcare. However, government expenditure in the private sector may increase due to the anticipated flow of patients from the uninsured population into the private healthcare sector as the NHI system is being implemented. The NHI White Paper (2015) holds that,

> The private sector health expenditure by medical schemes in 2014/15 was estimated at R139.1 billion. This amount includes preliminary estimates of R20 billion which is the State's contribution to some medical schemes as a subsidy for state employees (This figure excludes contributions by the state to Polmed, Parmed and State-owned entities). There is also an additional R16 billion in tax credits provided by the state to members of medical schemes, whether employed in the public or private sector. These amounts are not available for the uninsured population.[44]

In view of the above quotation, and according to the NHI White Paper (2015) the NHI Fund "will be the single, strategic purchaser of personal health services for the population. The Fund will contract directly with accredited public and private facilities."[45] In relation to services purchased from private specialists, the NHI system will initially use a capped case-based fee

[41] Shivani and McLeod, 'Private Sector Perspectives on National Health Insurance,' 188.

[42] Downie and Angelo, 'Counting the Cost of South Africa's Health Burden,' 13.

[43] *National Health Insurance Policy: Towards Universal health Coverage*, 28.

[44] *National Health Insurance Policy: Towards Universal health Coverage*, 48.

[45] *National Health Insurance Policy: Towards Universal health Coverage*, 48.

adjusted for complexity where appropriate for reimbursement.[46] The revised NHI White Paper (2017) effectively keeps the key ideas in the NHI White Paper (2015) intact. Consequently, in the shift from policy to legislation, the NHI Bill (2018) will apply to public and private health establishments.[47] The legislation begins by making as precise as possible distinctions between the private and the public sector (as different elements with varying properties of the two-tiered healthcare system). The NHI Bill (2018) creates a legislative framework for entry into contracts with certified and accredited public and private service providers. It creates a legislative framework for the NHI policy without dismantling the two-tiered system. Moreover, Ramjee and McLeod further assert that,

> The payment system, which currently for private sector doctors is predominantly fee-for-service, is proposed to be changed to a system of mainly capitation for primary care and global budgets for hospitals. This proposal will change the incentives of doctors and introduce a disincentive to contract with the [NHI Fund] if private providers know they will still be able to serve the same volume of private patients under [the] NHI system.[48]

The NHI Bill (2018) states that, "A person who is eligible to become a beneficiary of the Fund…must register him or herself and his or her dependents as users with the Fund at an accredited public or private healthcare establishment or facility."[49] The relationship between the two sectors turn the NHI Fund into a coherent organization with its own identity and autonomy to pay for private patients. This will increase the volume of private patients under the NHI system. The NHI Bill (2018) makes provision for a Benefits Advisory Committee that will comprise, amongst other members, two persons nominated by the hospital association or similar body representing the private hospitals.[50] Private medical service providers tend to work in both sectors. It is this double reality that the two sectors are linked together and return dialectically into the total movement of the healthcare system.

The impact of neoliberalism on the popular classes, and the massive social polarization along with the vast growth of the working-class and the urban population with which it is associated, might be expected to lead to widespread class struggles and a radical, even revolutionary

[46] *National Health Insurance Policy: Towards Universal health Coverage*, 71.

[47] *National Health Insurance Bill* (Department of Health: Republic of South Africa, 2018), 17.

[48] Ramjee and McLeod, 'Private Sector Perspectives on National Health Insurance,' 188.

[49] *National Health Insurance Bill*, 26.

[50] *National Health Insurance Bill*, 39.

popular politics.[51] That which is common to both sectors is that healthcare is a product of *labour*.[52] Dialectical materialism, as a theory of social and economic structures and their mechanisms of change, sheds light on the problem of the conditions of the working-class (all of which are instruments of *labour).*[53] It allows for an understanding of the exploitation of the working-class as part of a general system of exploitation.[54] The two healthcare systems continue to develop in opposition to one another, one private and the other public; to one sector (private) healthcare is treated as a *commodity* to be sold and traded in the free market system at an expensive price; to the other sector (public) healthcare is treated as a *use-value* to be offered *for free* to the poor masses financed by the democratic government. It is my position that there should not be a differentiation such as private or public sector or private medical practitioner and public medical practitioner, there should simply be the healthcare sector and medical practitioner – in a *unified* system (a single tier). Private practitioners as healthcare providers including private general practitioners (GPs) and specialists should not benefit from the NHI system unless they are willing to work and offer their skills and expertise in the public healthcare sector *only* and be paid by the state as public servants. The idea of a private medical doctor or specialist in private practice should come to an end in South Africa.

The problem is that the NHI Fund, according to the NHI Bill (2018), must actively and strategically purchase healthcare services from both public and private healthcare providers on behalf of users.[55] Also, emergency Medical Services provided by accredited and contracted public and private providers must also be funded by the NHI Fund. It is legislation. But such legislation needs to be challenged. The NHI Bill (2018) further states that, "Public and private service providers accredited by the Fund in terms of this section must deliver health service benefits at the appropriate level of care to users who are entitled to benefits that have been purchased by the Fund on their behalf."[56] An important observation for the NHI system is that patients will receive public healthcare *for free* – the conceptual category of *healthcare provision*. Those seeking private healthcare shall cover their own private healthcare costs where healthcare is *for sale* – the conceptual category of *healthcare purchasing*. This creates

[51] Lucien Van der Walt and Michael Schmidt, *Black Flame: The Revolutionary Class Politics of Anarchism and Syndicalism* (Johannesburg: AK Press, 2009), 11.

[52] Vladimir I. Lenin, *The teachings of Karl Marx*, Vol. 1 (New York: International Publishers, 1935), 19.

[53] Thomas Sankara, *Thomas Sankara Speaks* (Cape Town: Pathfinder Press, 1988), 262.

[54] Sankara, *Thomas Sankara Speaks*, 262.

[55] *National Health Insurance Bill*, 48.

[56] *National Health Insurance Bill*, 51.

room for a co-existence of the medical aid/insurance system with the NHI system. In the public healthcare system, within the context of the NHI system, healthcare is de-commodified, it is a use-value. It is provided for free for the patient (not exchanged for money through out-of-pocket payments by patients). Therefore, as a use-value it is not a commodity.[57] It is de-commodified. Healthcare can be a product of human labour without being a commodity.[58] Yet, in the private healthcare system healthcare is conferred a second existence. Its value is duplicated into both a use-value and an exchange-value. It is commodified and then commercialized. In a market economy healthcare is purchased at an expensive cost.

6.4 Universal health coverage and a single tier system

In the reconstitution of the South African healthcare system as a given concrete totality, each complex determination emerges dialectically where each sector has a logical and methodological role. Neoliberalism and the private healthcare sector have its place in the explicative whole. In other words, for crude self-interest, through a free market, to create major social benefits, there should be a strong and lean state, able to enforce law and order as well as private property rights.[59] Hence, South Africa is a country that has a two-tiered healthcare system. Its NHI model is of an insurance scheme that seeks to include private hospitals as providers of healthcare. The creation of this neoliberal system entails much destruction.[60] There are deep concerns with overcoming the potentially divisive impact of the NHI legislation. There is evidence that shows that there is a tilted distribution of health facilities and resources, with the formal private healthcare sector mostly concentrated in urban and richer areas and employing the majority of the medical specialists.[61]

In Boksburg, (Birchwood, October 2018) a Presidential Health Summit was held which served as an avenue to bring together key stakeholders from different constituencies, to deliberate and propose solutions to address the challenges in the healthcare system through an inclusive

[57] Fine and Saad-Filho, *Marx's Capital*, 15.

[58] McLellan, *Karl Marx: Selected writings*, 425.

[59] Van der Walt and Schmidt, *Black Flame: The Revolutionary Class Politics of Anarchism and Syndicalism*, 11.

[60] Harvey, 'Neoliberalism as creative destruction,' 23.

[61] Sulakshana Nandi, Helen Schneider, and Samir Garg, in 'Assessing geographical inequity in availability of hospital services under the state-funded universal health insurance scheme in Chhattisgarh state, India, using a composite vulnerability index,' *Global Health Action*, Vol. 11, (London: Taylor & Francis Group, 2018), 1. Though they document the case in India, it resonates with the South African context. At the national level, the *Rashtriya Swasthya Bima Yojana (RSBY)* or the National Health Insurance Scheme, a state funded scheme for hospitalization, was introduced by the Government of India in 2007.

process.[62] A report was written after the summit. A key position (which reflects the approach of the NHI policy and legislation) in the Presidential Health Summit Report is that, "The reality of the existence of both the public and private sectors in South Africa must be recognised. [The private sector] has a critical role to play in the realisation of UHC and the vision of the NHI, thus, a harmonious working relationship between private and public sectors is key."[63] The complex systems perspective does away with the mechanistic split of "private" and "public" sector wherein both are merely particular types of relations. Notice that the private sector in South Africa must be recognised instead of being negated. However, there can never be harmony between the two sectors. There can only be competition. The interactions and the relationship between the two sectors have *emergent* properties, that is, properties that cannot be reduced to the properties of the private and public sectors as separate sectors. A systemic *collapse* of the public healthcare system is an *emergence*. Moreover, to improve the country's healthcare indicators the creation of a state-led single-tier system needs to be clearly reflected in the NHI system and articulated in the NHI legislation. Otherwise, the opportunity for the provision of healthcare services, to improve the population's healthcare needs, becoming the responsibility of the state *only*, and not including the private healthcare sector is eliminated.

The deputy president (David Mabuza) has stated that, "The Presidency has taken stewardship of the NHI process and consequently the development of a quality health system in support of [the national Department of Health (DoH)] to ensure that the country achieves affordable quality healthcare."[64] The Presidency of South Africa will lead the national implementation of the NHI and shall have oversight over provinces and various government departments that will be involved in the implementation process (namely: Health, National Treasury, Cooperative Governance and Traditional Affairs [COGTA], Public Services and Administration, Public Works, Home Affairs and Science and Technology).[65] The goal is that, by 2030, the healthcare system should provide quality healthcare to *all for free* (at the point of service) using both sectors. The option is a market solution. This reform supports commodification,

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[62] *Presidential Health Summit 2018: Strengthening the South African health system towards an integrated and unified health system*, 13.

[63] *Presidential Health Summit 2018: Strengthening the South African health system towards an integrated and unified health system*, 10.

[64] *Presidential Health Summit 2018: Strengthening the South African health system towards an integrated and unified health system*, 17.

[65] *Presidential Health Summit 2018: Strengthening the South African health system towards an integrated and unified health system*, 63.

commercialization, privatisation, and competition in the healthcare system.[66] Yet, capitalist exploitation in South Africa cannot be easily dissociated from racial exploitation. Therefore, the NHI system in its current formulation runs the risk of safeguarding and expanding the established fragmented healthcare system. The private healthcare sector must be nationalized if it is to benefit from the NHI system. The important question is that of control, and ownership. The entire healthcare system as a strategic sector of the economy has got to be taken under full state control and ownership.

The existence of a unified healthcare system depends upon the unity of the private healthcare and the public healthcare sector. As dialectical opposites both sectors are unified in some broader relation. Both sectors also depend on the existence of the state. Mabuza suggests that a private healthcare sector that is funded by the state (and economically endowed users directly) and through contributions by medical aid schemes is far better resourced than the public sector that is funded through the fiscus.[67] Thus, neoliberalism has, in short, become hegemonic as a mode of healthcare discourse and has pervasive effects on ways of thought and political-economic practices to the point where it has become incorporated into the commonsense way of interpretation, and understanding of the healthcare system.[68] In the NHI policy and legislation, the private healthcare sector and public healthcare sector are apparently being united. There is also a purchaser-provider split. The existence, movement, and the current flow of the healthcare system will depend upon this relationship and split. However, such neoliberal policies increase inequality between the two sectors to a point where a contradiction in the relationship exists. Such policies are associated with the casualization of labour, the commodification and the privatization of healthcare. Privatisation has not only been seen in healthcare services, but in various public services. Free trade, the expansion of transnational corporations, rising unemployment, and substantial cutbacks in state-provided services, all create a dystopia of endless exploitation.[69]

Unfortunately, South Africa has adopted a neoliberal NHI system as a state-funded health insurance scheme and as a strategy for achieving UHC. Joe Kutzin (World Health Organisation,

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[66] Sulakshana Nandi, 'Struggle Against Outsourcing of Diagnostic Services in Government Facilities: Strategies and Lessons From a Campaign Led by Jan Swasthya Abhiyan (People's Health Movement) in Chhattisgarh, India,' Journal of Social and Political Psychology, Vol. 6(2), (London: Psych Open, 2018), 2195.

[67] *Presidential Health Summit 2018: Strengthening the South African health system towards an integrated and unified health system,* 17.

[68] Harvey, 'Neoliberalism as creative destruction,' 24.

[69] Van der Walt and Schmidt, *Black Flame: The Revolutionary Class Politics of Anarchism and Syndicalism,* 11.

Coordinator: Health Financing and Policy) defines UHC as enabling all people to use health services that they need – that are of sufficient quality to be effective; and to ensure that the use of these services does not expose the user to financial hardship.[70] The dominant view, according to the Presidential Health Summit Report (2018) is that in the context of South Africa, the NHI provides an avenue towards ensuring UHC; and to address the challenges faced by the South African health system, and to achieve UHC, requires the involvement of both the public and private sectors. In this instance, neoliberal doctrine and practice is continuously and intensively applied to the healthcare system, through offering free public services using private sector institutions and the introduction of market-based arrangements to those areas of government offering healthcare services that remain un-privatized. Hence, the healthcare system needs to be consolidated into a single public/state system. Shivani and McLeod assert that,

> [One] of the outstanding areas of major debate [since 2007, is the] issue of a single-tier versus a multi-tier system. A key area of ongoing debate is the extent to which it is feasible to have a single tier system (where all South Africans have access to exactly the same range of services and types of healthcare providers) or whether a multiple-tier system (where there are differences, particularly in terms of the type of provider that can be used by different groups) is inevitable.[71]

Resistance to a single-tier system forms part of an ideological process. This ideological process can be understood within its racialized historical context. Its mode of production is structured according to its race and class relations. According to this structure, people enter specific social and economic class relations with each other: (1) *capital* (owners of the means of production) and (2) *labour* (wage earners, sellers of labour power). At the centre of the policy of privatization is a belief in the free market. As a result, privatization and deregulation in the healthcare system polarizes race and class relations between *capital* and *labour*. However, in the development of the NHI system, a negation (transformation) must result – wherein the private healthcare sector necessitates that it be turned into its opposite – the public healthcare sector. This is a law of material dialectics, the law of development through contradiction, often referred to as the law of the negation of the negation. This element of dialectical materialism comprehends the dynamic aspects of another law and its direct application to movement and

[70] *Presidential Health Summit 2018: Strengthening the South African health system towards an integrated and unified health system,* 20.

[71] Shivani and McLeod, 'Private Sector Perspectives on National Health Insurance,' 189.

change. These laws are dialectically related. They explain that the interactions of opposing forces result in change. A negation of the negation needs to further take place resulting in a synthesis – a single-tier system. Such a synthesis shall bring about a new creation – a *unified* system (a single totality). A *unified* system is important because the private sector provision costs are affordable only to a few, as per the findings of the Health Market Inquiry.[72] But, Shivani and McLeod hold that,

> Universal coverage does not necessarily mean a single-tier system. Universal coverage can be achieved through a combination of funding methods (i.e. a multi-tiered system). The World Health Organization (WHO) urged governments in Africa to develop plans for universal protection against the financial burden of illness, that might include a combination of tax-based financing, mandatory social health insurance and private insurance in a multi-tier system. Much careful work is needed to find an equitable solution that accommodates a multi-tier system.[73]

Contrary to the above view, universal health coverage means a single-tier system. Unfortunately, according to the Presidential Health Summit Report (2018), healthcare services and products in South Africa should be paid for by *publicly provided*, or *privately funded* insurance in a multi-tier system. Thus, it is contradictory to engage the private sector meaningfully, such that the inclusive process and mechanism that is started through the Presidential Health Summit be sustained by providing collective leadership and stewardship to unify both these sectors around common goals.[74] The NHI system sets up a hybrid regime in the healthcare system. It has adopted both neoliberal and interventionist strategies. However, social conditions in South Africa are characterized by a dialectical inversion with regards to healthcare.

The government has subsidized the private healthcare sector, thereby keeping the two-tiered system intact. Thus, in a democratic context the private healthcare sector uses a higher proportion of the Gross Domestic Product (GDP) to serve only private healthcare sector users who make up a minority (16%) of the population. Yet, poor, rural, township, and squatter settlement communities have a very high dependency on the public healthcare sector, while the

[72] *Presidential Health Summit 2018: Strengthening the South African health system towards an integrated and unified health system*, 17.

[73] Shivani and McLeod, 'Private Sector Perspectives on National Health Insurance,' 189.

[74] *Presidential Health Summit 2018: Strengthening the South African health system towards an integrated and unified health system*, 9.

public healthcare sector uses a lower proportion of the GDP to service the majority (84%) of the population. In this context, both the two-tiered system and the single-tier (*unified*) system must be made known to obtain a proper understanding of the healthcare system. Otherwise, it appears that the conglomerate private healthcare sector economically benefits the owners of the means of conglomerate private healthcare production only. Shivani and McLeod maintain that,

> Given the political history of legislated discrimination on the basis of race under apartheid, there is clearly a desire to avoid health system differentials on the basis of [race and] class…A single-tier system, whereby all South Africans have access to private sector services, is simply unaffordable in the context of South Africa's level of economic development.[75]

Again, the above view is correct. Hence, I argue that a single-tier system whereby all South Africans have access to *public* sector services is simply *affordable*. Moreover, there must be a desire to avoid healthcare system differentials based on race and class. Race and class are aspects or factors that explain any dynamic in the South African post-apartheid social and political situation. Yet, neoliberalism is the defining political economic paradigm of our time – it refers to the policies and processes whereby a handful of private interests are permitted to control as much as possible of social, political, cultural, and economic life in order to maximise their personal profit.[76] Thus, Mabuza holds that,

> The challenges in both the public and private health sectors require a new approach to serve all South Africans and meet the constitutional mandate of the progressive realisation of the right to healthcare. An integrated health system for all – through an NHI is required where access to quality healthcare is not dependent on one's economic status as is currently the case.[77]

In the above quotation, the integration of two different sectors is the dominant economic ideology.[78] To turn the neoliberal rhetoric against itself, in whose interests is the state's neoliberal stance? In what ways have those interests used neoliberalism to benefit themselves rather than, as is claimed, everyone, everywhere?[79] Therefore, in the implementation of the

[75] Shivani and McLeod, 'Private Sector Perspectives on National Health Insurance,' 189.

[76] Chomsky, *Profit Over People: Neoliberalism and Global Order,* 7.

[77] Presidential Health Summit Report (2018), 17.

[78] Van der Walt and Schmidt, *Black Flame: The Revolutionary Class Politics of Anarchism and Syndicalism,* 11.

[79] Harvey, 'Neoliberalism as creative destruction,' 24.

NHI system, towards the achievement of UHC, the private healthcare sector in South Africa needs to be negated. South Africa is still largely an unequal and divided society. It is divided by race, class, ethnicity, income, location, and property relations. In such a society, there are racialized inequalities of wealth and power. The inner contradiction of South African society is that it is dominated by the neoliberal paradigm of privatization. Hence, the private ownership of the main means of healthcare production. The Presidential Health Summit (2018) recognises the centrality of the NHI and the combined roles of the public and private healthcare sectors in meeting the overall aspirations and goals of South Africa's national healthcare system in achieving UHC.[80]

The NHI model provides a context for cases where both healthcare and healthcare practitioners become commodified – where healthcare workers are hired in private hospitals (or private healthcare facilities) as wage workers to produce healthcare as an expensive commodity for sale at a profit – wherein capitalism becomes the exclusive mode of healthcare production in South African society. However, capitalism is not merely a system of commodity production, but also, more crucially, it is a system of wage labour.[81] Neoliberal initiatives are characterised as free market policies that result in consumer choice, private profit maximization, and an encouragement of private enterprise and private profit (that is not invested into the fiscus).[82] In South Africa, free market policies hide the narrow concerns of capital to cut costs and to maintain profitability. Social relations of production within the private healthcare sector become specific to the mode of production of the private healthcare sector (and they reproduce themselves). The formation of numerous middle, intermediate, and transitional strata obscures race and class boundaries. Thus, in South Africa there are not just two homogenous classes (capitalist and proletariat) but multiple ramifications of the division of labour and the overdetermined specificity of the modes of production as well as historical conjunctures.[83]

6.5 Transformative negation of the private healthcare sector

Class structure has become a much more complex element of capitalist production in South Africa's social and economic formations. Under its continuous connected processes (processes

[80] *Presidential Health Summit 2018: Strengthening the South African health system towards an integrated and unified health system*, 15.

[81] Fine and Saad-Filho, *Marx's Capital*, 28.

[82] Chomsky, *Profit Over People: Neoliberalism and Global Order*, 7.

[83] San Juan Jr., 'Marxism and the race/class problematic: a re-articulation,' *Michigan Journal of Race and Law*, Vol. 11, Issue 15, (2005), 5. Retrieved from: https://repository.law.umich.edu/mjrl/vol11/iss1/5. Date: 15 March 2019.

of production and reproduction) capitalist production of healthcare produced healthcare privately as a commodity, but also produced and reproduced the capitalist relation: capitalists as owners and workers as wage labourers. The corporatization, commodification, commercialization and privatization of healthcare services have been features of the neoliberal project. Its primary aim has been to open-up new fields for capital accumulation in domains formerly regarded off-limits to the calculus of profitability.[84] Defenders of the neoliberal order claim that private healthcare must invariably be accessible to the broad mass of the population so long as the neoliberal policies that exacerbate problems in the public health system are not interfered with.[85] Anti-neoliberal struggles tend to be primarily defensive, directed against the effects of neoliberalism rather than addressing its causes and developing an effective, lasting solution. It took neoliberals many years to set up and accomplish their march through the institutions of contemporary capitalism; no less of a struggle is expected when pushing in the opposite direction.[86] The economic consequences of neoliberal policies have been the same just about everywhere, and exactly what one would expect: a massive increase in healthcare inequality, an unstable healthcare economy and unprecedented expansion of the private healthcare sector for a wealthy few conglomerates within the healthcare industry.[87]

Therefore, there should be no retreat from advancing socialism and implementing the policy of nationalization. There needs to be a policy shift and a re-shift in political economic thinking, without succumbing to pressure from external forces. The future of South Africa lies in its own style of socialist development of post-apartheid society and its own model of social ownership of property.[88] Upon the implementation of the NHI system the conglomerate private healthcare sector may be affected by its evolution which may transform (negate) it. An understanding of nationalization, its purpose, and its relationship to effective state ownership and control must be emphasized in relation to the transfer of legal ownership and control of private healthcare facilities to the state. Another law of material dialectics is concerned with qualitative change which accompanies all processes of change. Qualitative changes occur through transformations of quantity into quality and they take place at specific periods or positions in any course of development. Both the private healthcare sector and the public healthcare sector (as opposites) currently have the freedom of separate development. They are in a stage of simple

[84] Harvey, 'Neoliberalism as creative destruction,' 35.

[85] Chomsky, *Profit Over People: Neoliberalism and Global Order,* 8.

[86] Harvey, 'Neoliberalism as creative destruction,' 43.

[87] Chomsky, *Profit Over People: Neoliberalism and Global Order,* 8.

[88] Pallo Jordan, 'Crisis of conscience in the SACP,' *South African Labour Bulletin,* Vol.15, No.3, (September 1990), 66.

contradiction. However, (through the introduction of the NHI system) conditions may change and bring about a situation where the peaceful co-existence of the "opposites" is no longer possible. This is called a stage of antagonism. The result is a struggle which may lead to a new synthesis or to the destruction of the opposites. A two-tiered healthcare system (private/public, opposites) can be transformed into one healthcare system (a single totality).

The state's introduction of the NHI Fund in the healthcare system as a new financing mechanism must transform the two healthcare sectors: *unify* them by improving the quality of the public healthcare system but negate (transformative negation) the conglomerate private healthcare system – by bringing it into the ownership and control of the democratic state. The idea that the market is about fair competition will be increasingly negated by the facts of extraordinary monopoly, centralization, and internationalization on the part of corporate and financial powers.[89] Therefore, healthcare must be publicly provided, and publicly financed. This means that there will be access to *free*, quality, healthcare facilities for the entire population (citizens and non-citizens) through the public sector. A socialist system within healthcare must negate the private medical insurance industry. During the development of the NHI, a negation (of the conglomerate private healthcare sector) must be the result. Otherwise, the enabling (developmental) state has been crippled, its alternatives to liberal economics are found wanting, and as a result, popular opposition to neoliberal politics will remain unable to effectively confront the NHI system in a neoliberal order.[90] However, using conglomerate private healthcare institutions to offer *free* healthcare remains a contradiction. Hence, the first negation may in turn be negated (negation of the negation) to create a mutation (a new stage), a single healthcare system that is publicly/socially owned and that is *free for all* at the point of service (financed through the NHI Fund).

Privatization and capital accumulation within the healthcare system appears to be beneficial to the lower classes, but the long-term effects are negative.[91] The gap between rhetoric (for the benefit of all) and realization (for the benefit of a small ruling-class) increases over space and time.[92] The neoliberal system therefore has an important and necessary by-product – a depoliticized citizenry marked by apathy and cynicism.[93] The neoliberal emphasis upon

[89] Harvey, 'Neoliberalism as creative destruction,' 38.

[90] Van der Walt and Schmidt, *Black Flame: The Revolutionary Class Politics of Anarchism and Syndicalism,* 12.

[91] Harvey, 'Neoliberalism as creative destruction,' 38.

[92] Harvey, 'Neoliberalism as creative destruction,' 48.

[93] Chomsky, *Profit Over People: Neoliberalism and Global Order,* 10.

individual rights and the increasingly authoritarian use of state power to sustain the system becomes a flashpoint of contentiousness; neoliberalism is recognized as a disingenuous and a utopian project masking the restoration of race and class power.[94] Therefore, the healthcare system must be nationalized and publicly-funded, and must provide universal health coverage to the country, but in a single-tier. There must also be a distinction between a legal change of ownership from private ownership to state ownership, and the process called socialization (social ownership).[95] Nationalization is caused to vary through socialization: the process of transforming an economic activity (*e.g.* healthcare) into a social and economic relationship and collective endeavor (social ownership). Without socialization, the key condition for de-alienation shall continue to be absent.[96] The socialization of production cannot fail to lead to the transfer of the means of production.[97]

The assumption in the socialization of healthcare (as an alternative to the privatization of healthcare) is that at a socialization level, the patients shall receive healthcare products and/or healthcare services for *free* at the point of care (the distinctions are – *free*: socialization; *fee*: privatization). However, healthcare centres may not be controlled by the state but shall receive (performance based) capitation from the state through the financing mechanism of the NHI Fund. In this framework, the means of production are: *(i)* Healthcare facilities, *(ii)* Medical machinery (and/or healthcare technology), *(iii)* Medical tools (and/or medical instruments), *(iv)* Infrastructural capital and *(v)* Natural capital. Therefore, a healthcare facility (for example, a hospital, or a clinic) may be referred to as the means of production. Now the central question is: *for sale* (commodified) at the point of care/service – within a capitalist framework; or *for free* (de-commodified) at the point of care/service – within a socialist framework?

In the current framework of the NHI policy and legislation, the NHI as a financing mechanism can procure/purchase healthcare products or healthcare services on behalf of the patients at the point of care/service. Hence, the insistence for the inclusion of the conglomerate private healthcare sector. The argument is that it is *free* for the patient because the NHI Fund will *pay*. In this argument there is a purchaser/provider split, where the government is the purchaser and the private sector is the healthcare provider. Hence, I argue that such a model will invariably lead to, or result in, the expansion of the conglomerate private health sector and the collapse of

[94] Harvey, 'Neoliberalism as creative destruction,' 42.

[95] Gavin Evans, 'Interview with Joe Slovo,' *South African Labour Bulletin*, Vol.39, No.1, (February/March 2015), 57.

[96] Slovo, 'Has socialism failed?' *South African Labour Bulletin*, Vol. 14, No.6 (February 1990), 24.

[97] Lenin, *The teachings of Karl Marx*, 29.

public healthcare. A new variable, the NHI Fund, would have been inserted into the system. However, the government is already offering healthcare services itself. Therefore, there is no contradiction in the government being the purchaser of its own healthcare services through the NHI Fund and being the provider of its own public healthcare services which, in this case, will be offered for free to the population: free medical care and free hospitalization for all would be achieved. Effectively, the government will purchase services from itself and for itself (contracting public healthcare workers) for the benefit of the population, and the government can improve the quality of its own healthcare services to be beyond that of the conglomerate private healthcare sector. It would have the money to do so. If the assumption is that the patients shall receive healthcare products (for example, pharmaceutical products) and/or healthcare services (curative, preventive, rehabilitative, and palliative care) for *free* at the point of care, then, in this context, the patients can have an "NHI card" that enables them to receive quality healthcare services/products for *free* at the point of care, through the NHI Fund as a financing mechanism in a healthcare system that is in a single-tier

The form of ownership of the healthcare facility (hospital, clinic, pharmacy) may be a form of social ownership. Social ownership refers to a form of ownership of the means of production in an economic system entailing for example a partnership between: *(i)* Public ownership (state ownership); *(ii)* Employee ownership [for example, this could mean the nurses, dentists, doctor(s), optometrists, paramedic(s), audiologists, community healthcare workers (CHWs) or members of the healthcare team]; *(iii)* Cooperative ownership (ownership by the medical and non-medical staff) of the healthcare centre (hospital, clinic, pharmacy) inclusive of the community (including patients, who can also become members of the cooperative). This is an example of socialization of the means of production: an example of the building of healthcare centres outside of the private sector. In addition, and most importantly, socialization of the surplus value appropriation may occur at this point, after the socialization of the means of production has taken place. Private hospitals that are owned by the conglomerate and monopolized private healthcare sector, when transformed (negated), can become a case of social ownership and not private ownership.

The implementation of the NHI system must be consistent with the global vision that healthcare should be a social and economic investment. Thus, in my view, healthcare should not be subjected to market forces where it is treated as a normal commodity of trade. Healthcare is a government priority area. A contradiction develops between socialized healthcare production and private ownership of healthcare facilities and appropriation of the surplus value and profits.

This contradiction will intensify to a point where socialization of the surplus value appropriation in the form of social ownership of the means of production will be necessitated, resulting in a transition from capitalism to socialism. To advance the socialist objective, nationalization and socialization (change of private ownership) must ensure democratic participation by the producers of healthcare at all levels of the economic life of the healthcare system. The public healthcare system needs to function in a single-tier if the NHI programme is to be rolled out successfully.

A qualitative change can occur through the transformation of quantity (two sectors, dual system) into quality (one system, *unified*) in the development of the healthcare system. The conglomerate private healthcare sector can transform into a physically (radically) different character. The introduction of the NHI (a quantitative change) can bring about a qualitative transition – a *unified* healthcare system (a single totality). Quantitatively, the conglomerate private healthcare sector and the public sector may be combined into a single totality. In the two sectors, private (negative) and public (positive), there is no aspect in them in which a contradiction cannot be found: that is two necessary and conflicting determinations.

The two terms – private and public – are in contradiction. They are in opposition. Whatever is contradicted cannot be reduced to an abstract nothingness, but essentially to the negation of its particular content. In other words, such a negation is not a complete negation but the negation of the determinate thing which is being dissolved (the private healthcare system), therefore a determinate negation. These two variables (private and public) provide assumptions and present two decisive assumptions/factors: the collapse of the public healthcare sector and the expansion of the conglomerate private healthcare sector. If the logic is to offer free healthcare to all using private healthcare sector institutions/facilities, the main assumption is that the NHI Fund as a financing mechanism will cause the (gradual) expansion of the conglomerate private healthcare sector. Hence, the argument that the two sectors must be transcended: to become a single, unified healthcare system – the result of a determinate negation which has a content: a new concept (unified), a higher and richer than the previous one, having been enriched by its negation or, in other words, its contrary; it contains the other (private) but is also more than the other (public), it is their unity – *a unified healthcare system*, one system – a new moment of being and of thought and action, a resolution. It may now be possible to imagine universal health coverage (UHC) and *free* healthcare "at the point of care," for all. A *unified* healthcare system, which is a synthesis, is a determination that shall emerge from its predecessors – the private and the public sectors.

6.6 Conclusion

Neoliberals cannot and do not offer an empirical defence for the world they are making. To the contrary, they demand confidence in the infallibility of an unregulated market. For the defenders of neoliberalism, there is no alternative. Neoliberalism is the only feasible course for them. In this chapter, I compared expectations that are deduced from neoliberal ideology, its logical terminological foundations, concepts and relational structure. The goal was to identify the ideological underpinnings of the NHI policy and legislation within a discursive context. In analysis, theoretical expectations were combined to evaluate the relevant explanatory power of two ideologies for the policy under investigation. Specific propositions and concrete predictions from abstract theories were deduced. The theories that were selected in the chapter are neoliberal theory (neoliberalism, privatisation) and socialist theory (socialism, socialisation). Reflecting on privatisation, neoliberalism, and capitalism (as paradigms, or meta-theories) the insights gained have been used to assess the relevance of contradictory theoretical approaches in the NHI policy and legislation. In the analysis, the questions that were asked are: does neoliberalism and capitalism as an ideology provide a better explanation (does it have relevant explanatory insights) in comparison to socialism with regards to a *unified* healthcare system (in a single totality)? The answers where that it does not. The only alternative is to advance socialism. In the next chapter, I provide a brief analysis of the NHI's focus and approach: that of Community Health Care Workers (CHWs) and the strategic reengineering of primary healthcare.

Chapter 7

Primary healthcare reengineering and financing of the NHI system

7.1 Introduction

The previous chapter compared expectations that are deduced from neoliberal ideology, its logical terminological foundations, concepts and relational structure. In it, I identified the ideological underpinnings of the NHI policy and legislation within a discursive context. Also, theoretical expectations were combined to evaluate the relevant explanatory power of two ideologies for the policy under investigation.

This chapter explores primary healthcare re-engineering as an aspect of the National Health Insurance (NHI) policy and integrates an element of financing arrangements in the national implementation of the NHI system. It offers an account of the strategy for primary healthcare reengineering including how the NHI will be funded and then integrates relevant policy documents in this regard. An overview of primary healthcare reengineering and NHI financing in the public healthcare sector is provided. However, there is a recognition that healthcare system financing remains an element that requires further research. Also, I offer a discussion of a development strategy for human resource for health (HRH) as an imperative in the sustainability of the NHI system.

7.2 Primary healthcare reengineering

Historically, the Reconstruction and Development Programme (RDP, Article 2.12.5.8) had argued that, "The whole [National Health System (NHS)] must be driven by the [primary healthcare approach]. This emphasizes community participation and empowerment, inter-sectoral collaboration and cost-effective care, as well as integration of preventive, promotive, curative and rehabilitation services."[1] This approach accounts for how the system must be reorganized (reengineered) for the purposes of producing healthcare and for distributing it. However, there was a perceptive shift from the NHS to the NHI (as I noted in chapter 3) and the NHI system received support in South Africa instead of the NHS. There was also a widespread call for the implementation of the NHI system. Moreover, to implement the NHI

[1] African National Congress (ANC), *The Reconstruction and Development Programme (RDP): A Policy Framework,* (Johannesburg: Umanyano Publications, 1994), 45.

system successfully (as I emphasized in earlier chapters) there needs to be a consideration of the race and class structure of South African society. Thus, in the capitalist mode of healthcare production that is also racialized there is an ensemble of unequal productive and distributive relations that constitute the healthcare system. This mode of production generates institutions not only for the management of the healthcare system but to support the continued operation of the healthcare production system in its current two-tiered structure. In such a system, the NHI White Paper (2015) states that, "Implementation of the NHI will take place in three [3] phases over a fourteen (14) year period.

The first phase takes place over a period of five years and includes [the] strengthening of the service delivery platform and the overall improvement of quality in the public health sector" (as also noted in chapter 4).[2] Relatedly, in order to implement the NHI system, the goals of the National Development Plan (NDP, 2012) require that: *(i)* primary healthcare teams be established throughout the country with the required number of doctors, specialists, physicians and nurses; *(ii)* with each household having access to a well-trained Community Health Worker (CHW); *(iii)* schools must receive health education provided by teachers and primary healthcare teams; *(iv)* primary healthcare teams must have adequate resources for the services they need to deliver.[3] These four (4) points in the NDP (2012) have to do with the reengineering of primary healthcare or otherwise referred to as the "Gluckman approach" (as also noted in chapter 5).[4]

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[2] *White Paper on National Health Insurance (NHI) for South Africa – Towards universal health care coverage* (Department of Health: Republic of South Africa, Thursday, 10 December 2015), 2.

[3] *National Development Plan (NDP) Vision 2030: Our future – make it work* (Presidency: National Planning Commission, 2012), 331.

[4] Louis Reynolds, 'Health for all? Towards a national health service in South Africa,' in a book entitled, *New South African Review 1: 2010: Development or decline?* (Chapter 14) Edited by John Daniel, Prishani Naidoo, Devan Pillay and Roger Southall (Johannesburg: Wits University Press, 2010), 331. Regarding the "Gluckman approach," Reynolds explains that, "The first "Gluckman" health centre began in December 1945 at Grassy Park, in Cape Town, followed by Lady Selborne and Tongaat in 1946. Cradock and White River were set up in 1947. By 1953 there were more than thirty [30] ["Gluckman" health centres], and by 1960 the number had grown to more than forty [40]. Most stressed promotive health education (through ante-natal clinics, mother and baby clinics or the examination of school children), as well as preventive measures (through improved nutrition, immunization and vaccination), but the importance of curative medicine in treatment of disease (through the outpatient clinic or district nursing station) varied considerably." I have shown this in Chapter 5, see footnote 4. Most of the health centres were starved of resources and consequently closed or reduced to a cheaper option for offering poor healthcare to African people. Though hospitals were favoured, the concept of healthcare centres re-emerged again in the 1960s. In a Cosatu discussion document (12th National Congress: 2015, 40) it is noted that in 1942-1944 the National Health Services (NHS) Commission recommended a national health tax which was reversed after the Nationalist Party

Thus, the concepts that are presented in the NHI policy and legislation are indeed innovative but not entirely brand new, antithetical as they were to the apartheid government. Nevertheless, such concepts, also articulated in the NDP (2012), are identical to the points that appear in the NHI policy (2011, 2015, 2017) and legislation (2018).[5] The NHI policy holds that primary healthcare will be reengineered through four streams in order to improve timely access and to promote health and prevent disease; these streams are: (1) Municipal Ward-based Primary Healthcare Outreach Teams; (2) Integrated School Health Programme (ISHP); (3) District Clinical Specialist Teams (DCSTs); and Contracting of non-specialist Health Professionals. This reengineering programme clearly forms part of the implementation process of some of the targets that are found in the NDP (2012).

Central to the primary healthcare reengineering process are local CHWs. Cosatu's view is that local CHWs (from the local population) need to be trained (as they are a human resource that can potentially be made available) and employed in ward-based primary healthcare outreach teams to offer community oriented primary healthcare and to link community wide interventions with primary medical care using community epidemiology as a basis. The community-based healthcare teams must enter schools to deliver a health programme amongst school children. Conducted this way, the NHI programme may have wider sociopolitical implications. Off course, (as also noted in earlier chapters) the challenge lies in the contracting of private practitioners at the primary healthcare level to implement a state driven programme. Unfortunately, the NHI policy states that,

> To better utilize the available human resources for health in the country, there will be strengthening of contracting of private practitioners at the primary healthcare level. The expansion of contracted providers beyond general practitioners (GPs) will also include amongst [others,] practitioners dealing with physical barriers to learning such as audiologists, speech therapists, oral hygienists, occupational

government was elected into power in 1948 after which there was relative silence on substantive health system reform. I make reference to this also in Chapter 3.

[5] Reynolds, 'Health for all? Towards a national health service in South Africa,' 331. Reynolds further shows that, "When Gluckman became minister of health in November 1945, he had thought it necessary to reassure the profession by stating that those receiving curative care at health centres would not have been able to afford a private doctor, and that centres had only been set up 'in those areas where there are large numbers of people so poor that they cannot afford to engage the services of private practitioners'…When the National Party (NP) won the elections in 1948 the political environment changed drastically closing 'the window that had briefly opened for a more innovative approach'…The multiracial health teams embedded in the health centres were antithetical to the NP's programme of apartheid."

> therapists, psychologists, physiotherapists, and optometrists for school going children. This will focus especially on those children that have been identified in quintile one and two schools, during the period of piloting [the] NHI.[6]

What remains a problem is that an NHI dedicated and state-driven human resource development strategy for the skills and expertise that have been mentioned in the above quotation do not exist in the NHI policy and legislation. Therefore, in the piloting and the implementation of the NHI system, a new market has been established for the private health practitioners listed above (audiologists, speech therapists, oral hygienists, occupational therapists, psychologists, physiotherapists, and optometrists). Private practitioners, as individuals that make up the workforce for the NHI system, have not only a purely private profit interests at a personal level but also a social class status in healthcare production.

Accordingly, the NHI system aims to develop and increase their capital. Yet, private healthcare capital (founded on principles of private gain and exploitation) in South Africa is independent and has individuality. It also has race and class character (as also noted in chapter 6). In this context, the national Department of Health (DoH) had announced that there were eleven (11) NHI pilot districts where private practitioners where to be contracted: one (1) in each of the nine (9) provinces and three in KwaZulu-Natal that were launched in April 2012.[7] Some of the pilot districts were identified in the NHI Green Paper (2011). Similarly, the NHI White Paper (2015) points out that, "The health workforce [conceptualized in this way] is [the] key pillar of the health system and the planning, development, provisioning, distribution and management of human resources will be further improved to meet the needs of the population."[8]

It is this conceptualization that renders the NHI system not only fiscally unsustainable but practically unworkable. The assumption is that, if South Africa takes this route, then there will be active participation and cooperation on the part of private practitioners at a grassroots level.

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[6] *White Paper on National Health Insurance (NHI) for South Africa – Towards universal health care coverage,*'3. This quotation in the White Paper reflects the "Sydney Kark and Henry Gluckman Approach" to primary healthcare. See footnotes 4 and 5 above.

[7] Cosatu, *12th National Congress: Book 5* (Discussion Documents, 2015), 40. Cosatu has resolved to embark on Cosatu-led campaigns geared at supporting the government on the implementation of the NHI system through creating a national campaign on the NHI system with public healthcare workers at the forefront of the NHI campaign linked to the food security/sovereignty campaign; and improve training on NHI system through workshops; develop a booklet on the NHI system; and conduct constant engagements with the Department of Health (DoH) concerning challenges regarding the NHI system being "high-jacked" by the private sector; and develop a coherent provincial capacity building programme.

[8] *White Paper on National Health Insurance (NHI) for South Africa – Towards universal health care coverage,* 3.

Hence, it is further assumed that the utilization of the concept of the CHWs, in partnership with private practitioners and in implementing the NHI system, will assist the national DoH to address the human resource for health (HRH) that will be needed in order to implement the NHI system in communities successfully. These assumptions have not been clearly tested, yet the conviction is that this concept is transferrable to every province and generalizable nationally. But, a free labour market for the CHWs conceals exploitation. Moreover, its existence reproduces the privilege and power of the capitalist class. Hence, others have called for CHWs to be employed by the state. However, CHWs are inadequately educated neither are they medically trained to deal with the epidemiological challenges in the various communities wherein they are operational. Thus, the material conditions of the CHWs as a proletarian class in the NHI system will be reproduced for their continuing reproduction and exploitation.[9] Mosoetsa notes that,

> [There is an underlying] assumption that community-based care is cheap as costs are not measured and people are not properly compensated for their work…This is consistent with the low status that is accorded this sort of work. Nevertheless, the impact of HIV and AIDS has made the care of infected and affected people in households an undertaking of great importance, and there is a pressing need for organisations and people who are willing to take on the task, especially given the lack of capacity of the state with health services.[10]

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[9] In South Africa, there remains a class of post-modern capitalists who are owners of the means of production (both social and economic means of production). By proletariat, Oliver Tambo meant the majority of the people living in South Africa (the African majority) are in a class of wage labourers (working class, who must sell themselves piecemeal, and are reduced to a commodity, like every other article of commerce) who having no means of production of their own are reduced to selling their labour power in order to live. Tambo maintained that, "In our situation, we have to attach equal importance, at this stage, to organizing the exploited workers, organizing the oppressed masses. Therefore, we operate on …: the labour front [and] the front of mass popular actions…Over the years we have developed this organic link and we think that they knit together to constitute a force which the enemy will find very difficult to contain. [Taken from speeches, letters and transcripts from the compilation: *Oliver Tambo Speaks*, compiled by Adelaide Tambo, (Cape Town: Kwela) 256]. Oliver Tambo takes his concepts from Frederik Engels in the *condition of the working-class in England: From personal observation and authentic* sources (Moscow: Progress Publishers, 1892), were Engels says that, "The modern class of wage-workers who possess nothing but their labor-power and can live by only by the selling of that labor-power to others" (p.19).

[10] Sarah Mosoetsa, *Eating from one pot: The dynamics of survival in poor South African households* (Johannesburg: Wits University Press, 2011), 106. The NGP (2010) maintains that, there is a connection between economic and social measures and that these need to be further strengthened in addition to important social goals such as investment in health, including effective measures to address HIV/AIDS (p.22); and the NDP asserts that, "There are signs that the country has begun to turn the corner in response to an effective education and treatment campaign. The HIV infection rate has stabilised at about

The state, as Mosoetsa notes above, lacks capacity to deliver the NHI system. The assumption is that the NHI system is a mechanism that will capacitate the state in offering the services that Mosoetsa refers to above, and that such services can be offered effectively through the CHWs. However, these services are not cheap, and (as I have stated earlier) CHWs are not properly and formally educated in the healthcare profession neither do they have adequate healthcare skills and expertise. Moreover, the mode of healthcare production under which South Africa is organized is structured according to its modalities of profit extraction and capital accumulation. The state needs to be capacitated, not the private sector. Otherwise, racialised capitalism will coerce the majority, as a race and class, into the background, periphery, and margins of the healthcare profession and the healthcare system.[11] This will be due to the historical development of South African society being undergirded by a racist and an exploitative economic system. Race and class location in South Africa are a social power to exploit the proletarian majority. Nevertheless, the CHWs need to be adequately compensated for their work, and linked to the CHW teams should be well trained clinical specialists and professional public healthcare practitioners.

If phase one of the NHI system is implemented adequately by the state it has the potential outcome of drastically decreasing infant mortality rates including high levels of malnutrition amongst children. With primary healthcare reengineered, the country may be able to address the underlying social origins of preventable disease; and through the NHI system, the

10 percent. New infections among young people have fallen and life expectancy is rising. Despite these gains, there will still be a sizeable number of AIDS orphans and children requiring concerted support from the state and communities for decades to come. To maximise the benefits of this "demographic dividend" the country requires better nutrition and healthcare" (p.29). The NGP (2010) further suggests that, "Significant steps are being taken to address the challenge of HIV/AIDS and these will impact on the size and shape of the public [healthcare] infrastructure as well as improve the welfare and productivity of the workforce" (p.33). In addition, the IPAP (iterations) in terms of financing healthcare infrastructure, points out that between April 2013 and December 2013 IDC funding approvals included funding to the value of R393 million in healthcare (p.33). Furthermore, the IPAP (iterations) affirm that, "The South African pharmaceutical sector at the ex-factory price level was US$ 4.0 billion (R 36 billion) in 2012 – or just 0.4% of the global pharmaceutical market by value. South Africa's pharmaceutical market and industry are, however, by far the largest in Africa. South Africa also has the world's largest ARV programme, providing treatment to 2.2 million people in the public health sector and 150,000 in the private sectors (as at December 2013). The number of people on ART is expected to plateau at 3.7 million in 2017" (p.93).

[11] In the ANC there remains a class element that is neoliberal and pro-capitalism. As the ideology of neoliberal capitalism has dug deep into the fabric of the ANC, the efficacy of state ownership (nationalization) has been questioned, causing a shift in economic thinking within the ANC. The ANC has embraced a neoliberal culture, and this culture has spread deep into South African society. Contemporary South Africa has embraced neoliberalism.

Department of Health will ensure medical, dental, nursing, and hospital services to all sections of the population. With this type of approach to primary healthcare reengineering that the NHI White Paper advocates for, the home visits, and not the private clinic will become the basis for activity.[12] Effectively, the CHWs that are linked to a public healthcare centre will be practicing social medicine. Therefore, basic medical training for CHWs in this regard is crucial, including linking them up with nurses, seeing that the subject of personal healthcare is such a sensitive subject in communities. Thus, a Cosatu affiliate (Denosa) points out that:

> Nurses form the largest group of health professionals who are the closest and often the only available health worker to the population, with a greater responsibility to improve the health of the population as well as to contribute towards achievement of the global sustainable goals. The Department of health has introduced ward-based community health workers [CHWs] outreach teams, as part of a series of strategies to strengthen primary healthcare. The national policy has outlined that communities (wards) should have at least one [primary healthcare] outreach team comprising of a professional nurse, an environmental health officer, health promoters and 6-10 CHWs.[13]

If this process, as mentioned above, of primary healthcare reengineering succeeds to the extent that public healthcare centres that are linked to CHWs offer preventive and curative care, they will threaten private medical care practice especially medical doctors in private practice in communities.[14] Denosa resolved that, "Government should increase the number of nurses especially at primary healthcare level [and that] Government should absorb CHWs which are already doing excellent community health work."[15] Denosa further pointed out that,

> CHWs [were] not employed directly by the department, provinces [were] using different ways to pay them their stipend or pay resulting in unnecessary conflicts and tension thereby undermining the capacity to fully utilise these cadres. The current incentives aimed at attracting required skills to the rural areas [were] inadequate and divisive. Mishandling of the processes regarding the placement of nursing education may negatively affect the production of nurses both qualitatively and quantitatively, with [primary healthcare] and rural areas being

[12] Reynolds, 'Health for all? Towards a national health service in South Africa,' 330.

[13] Cosatu, *12th National Congress, Book 5*, 41.

[14] Reynolds, 'Health for all? Towards a national health service in South Africa,' 331.

[15] Cosatu, *12th National Congress, Book 5*, 41.

disproportionately affected.[16]

A crucial consequence of labour casualization has been to exacerbate poverty as the ability of workers to support dependents has been adversely affected; and that in poor households it is common that workers' wages are the main safety net. Hence, even the limited income available to low paid workers is eroded through support for the unemployed. Moreover, the disease profile (and therefore life expectancy) especially in the rural areas, reflects the socioeconomic situation in the country. However, Cosatu has cited in its Secretariat Report (2015) that according to the national DoH (2011), "South Africa suffers from the quadruple burden of disease. This term describes the prevalence of the following types of illnesses in the country: *(a)* HIV/AIDS; *(b)* Maternal, Infant and Child Mortality *(c)* Non-Communicable Diseases; *(d)* Injury and Violence." [17] In this regard, the NHI White Paper (2015) states that, "It is imperative that South Africa implements [the] NHI to achieve the goal of an integrated healthcare system that serves the needs of all, regardless of race, socioeconomic status and ability to pay for services."[18] Cosatu asks the question: will the NHI also cover the unemployed workers, those seeking for re-employment? The NHI White Paper's answer is that, "Implementation of [the] NHI is a reflection of the kind of society we wish to live in: one based on the values of justice, fairness and social solidarity."[19]

Nevertheless, given its resources, the South African government can afford to provide free healthcare services for all its citizens; though the healthcare economy has created gross and unnecessary inequalities. This means that they will have to depress the wages and salaries of the workers to the barest minimum at the cost of capitalist profits as they seek to preserve existing power structures. Cosatu, organized as a working-class movement is to use its political supremacy to wrestle healthcare capital from the capitalists and to centralize all instruments and means of healthcare production in the hands of the people (social ownership and control) and the democratic state (state ownership) and to advocate for the increase of the totality of healthcare productive forces as rapidly as possible. Race and class antagonisms shall remain, and the racial supremacist posture of a racialized capitalist class has not been overthrown. Hence, healthcare in South Africa is both political and ideological. There is no fairness, nor justice and social solidarity in such a system.

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[16] Cosatu, *12th National Congress, Book 5*, 41.

[17] Cosatu, *12th National Congress: Political and Socioeconomic Reports*, Book 2 (Secretariat Report, 2015), 174.

[18] *White Paper on National Health Insurance (NHI) for South Africa – Towards universal health care coverage,* 7.

[19] *White Paper on National Health Insurance (NHI) for South Africa – Towards universal health care coverage,* 7.

If one of the priorities is to draw all the different role players and services into the NHI system, then only public healthcare providers must be organised at national, provincial, district and community levels. The district health system embodies a decentralised, area-based, people-centred approach to healthcare and the World Health Organisation (WHO) identifies six (6) important elements of the system: (1) Service delivery; (2) Health workforce; (3) Health information; (4) Medical products, vaccines and technologies; (5) Sound health financing; and (6) Good leadership and governance.[20] In this regard, the NDP (2012) states that,

> A district-based approach to primary healthcare is part of the pilot phase of [the] national health insurance. For this approach to be successful, the health system needs more personnel (including professionals and paramedics), new forms of management authority, and strengthened statutory structures for community representation."[21]

Additionally, the NDP (2012) maintains that primary healthcare "emphasizes globally endorsed values, such as universal access, equity, participation and an integrated approach. Critical elements of primary healthcare include prevention and the use of appropriate technology."[22] A core component of primary healthcare reengineering is to emphasize population-based health and health outcomes. The NDP (2012) further corroborates that, "[reengineering primary healthcare] includes a new strategy for community-based services through primary healthcare outreach teams, based on community health workers. The strategy includes advocacy on major health campaigns, such as providing health information, and responding to issues identified by communities."[23] Communities must be encouraged to participate actively in the planning, managing, delivery, monitoring and evaluation of the health services in their areas.[24] This point is in line with the RDP (1994). Article 2.12.5.9 of the RDP (1994) had stated that, "All providers of health services must be accountable to the

[20] *National Development Plan (NDP) Vision 2030: Our future – make it work,* 331.

[21] *National Development Plan (NDP) Vision 2030: Our future – make it work,* 52.

[22] *National Development Plan (NDP) Vision 2030: Our future – make it work,* 330.

[23] *National Development Plan (NDP) Vision 2030: Our future – make it work,* 345. The NDP (2012) further states that, "The core of the primary health care outreach team will be a professional nurse, a staff nurse and community health workers. Many more trained nurses are needed, and their skills to carry out and support primary health care need to be strengthened. Community nurses will also need to be substantially competent in promoting health and preventing ill health. In several countries, community nurses (professional nurses with public health training) lead many aspects of district health work" (p.347).

[24] *Reconstruction and Development Programme (RDP), Article 2.12.5.3,* 44.

local communities they serve through a system of community committees."[25] Reform of the public health system had focused on the RDP (1994). Thus, the ANC-led government has modified the healthcare system and has introduced some benefits. These benefits such as "free healthcare for pregnant women and children under six" were reflected in, or came as result of, a policy position that is also held in the RDP (1994).

The concept of a "free" and "unified" healthcare system constantly emerges in the policy documents. I have dealt with these concepts in the previous chapter. To recap, according to the NHI Green Paper (2011), the key aspect of NHI policy is that, "access to health services *must be free* at the point of use and that people will benefit according to their health profile" (italics added).[26] Comparatively, the NHI White Paper (2015) also states that, "The health services covered by [the] NHI will be *provided free* at the point of care" (italics added).[27] The point is that free healthcare must be provided. The NHI Green Paper uses the concept of "free at the point of use," and the NHI White Paper uses the concept of "free at the point of care." There is a co-variation. However, the hospital/clinic, or any healthcare facility (for example, a pharmacy or medical centre) considered to be a "point of care," for patients shall provide services and products for free and shall be covered by the NHI Fund. My view is that such hospitals/clinics, pharmacies/medical centres as shall benefit from the NHI system or be contracted by the NHI Fund need to be insulated from the market system and from competition. To reach the outcome of free healthcare at the point of care/use/service, the NHI Fund as a financing mechanism or funding structure needs to be at variance with those of the market system. Otherwise, there remains a problem in the policy and legislative documents that stem from the NHI's characteristic methods – that of extending and deepening marketization within the healthcare system. The central problem with a neoliberal form of an NHI system lies in its design (and strategic location in the financial services sector) as having characteristics of a fund to purchase healthcare services on behalf of the entire population by co-opting the private healthcare sector and neglecting the development of human resources for health (HRH) within the public healthcare sector to sustain the NHI system.

[25] *Reconstruction and Development Programme (RDP),* Article 2.12.5.9, 45.

[26] *National Health Insurance Policy: Towards Universal health Coverage,* (Department of Health: Republic of South Africa 2015), 16.

[27] *White Paper on National Health Insurance (NHI) for South Africa – Towards universal health care coverage,* 9.

7.3 Human Resource for Health (HRH) and the NHI system

According to David Mabuza [deputy president of the African National Congress (ANC) and the Republic of South Africa], there are four major issues that impact negatively on the public healthcare system these are: *(i)* human resources, *(ii)* procurement or supply chain systems, *(iii)* financial management and *(iv)* maintenance of equipment and infrastructure.[28] Thus, it is imperative to address challenges relating to the first major issue, that of human resources for health (HRH). I would like to comment on HRH only. Other major issues that Mabuza has mentioned are aspects for further study. Firstly, any activity in the development of HRH that might interfere with corporate domination of society is automatically held suspect. It is made to automatically become suspect because it interferes with the workings of the free market, which is advanced as the only rational, fair, and democratic allocator of healthcare services. Hence, I argue that the moratorium on HRH development must be lifted.

The process of a racialized neoliberalization in South Africa has been geographically uneven, and heavily influenced by race, class structures, and other social forces moving for or against its central propositions within state formation and even within the healthcare system. This has negatively affected HRH development. Therefore, a national plan for HRH development for the healthcare system for sustaining the NHI system is desperately required. What Cosatu has noted is that, "A human resource strategy to increase the number of health workers was launched in October 2011."[29] This strategy failed, though healthcare is one of government's strategic policy imperatives. I have also noticed (as also noted earlier) that there is no HRH development strategy in the NHI policy and legislation [both in the NHI Green Paper (2011) and NHI White Paper (2015, 2017) and the NHI Bill (2018)]. If the government does not have an adequate framework and strategy to develop human resources for the healthcare system, the NHI system will not be sustainable. South Africa needs doctors, nurses, and health professionals in different occupational classes to deliver quality public healthcare.[30]

Tito Mboweni (Minister of Finance) struck a practical note in his budget speech (20 February 2019) when he affirmed that, "We need more doctors and nurses."[31] How the development of

[28] *Presidential Health Summit 2018: Strengthening the South African health system towards an integrated and unified health system* (Presidency: Republic of South Africa, 2018), 17.

[29] Cosatu, *12th National Congress: Discussion Documents,* Book 5 (2015), 40.

[30] *Medium Term Strategic Framework (MTSF) 2014-2019* (Presidency: Republic of South Africa), 22.

[31] Mayibongwe Maqhina, 'R4 billion allocated to NHI,' *Cape Times* (Thursday 21, February 2019), 1. To quote Mboweni, "R2.8bn has been reprioritised to a new human resource grant and R1bn has been added to raise the wages of community

HRH will occur in such a manner that we end up with a surplus of doctors and nurses in South Africa requires further research. Dr Nkosazana Dlamini-Zuma (former Minister in the Presidency: Planning, Monitoring and Evaluation) states that, "According to Health Professions Council of South Africa (HPCSA), there are 29 310 medical practitioners in South Africa and only 14 046 are in the public sector."[32] There are 15 264 medical practitioners that are in the private sector. There are 813 hospitals with 133 387 beds in service providing acute healthcare in South Africa; 404 of these are in the public sector with 101 862 beds [69%] and 409 in private sector with 41 297 beds [31%].[33] There are more private hospitals with acute healthcare facilities, and they have a lesser number of beds than the public healthcare sector. Private hospitals have more doctors and less beds and a lower number of patients. An analysis of figures for health professionals in relation to the general population indicates that, in 2006 a total of 33 220 medical practitioners were registered with the Health Professions Council of South Africa (HPCSA), thereby able to practice in the country. This represented a 14 percent increase since 1999 and an annual average growth of 1.9 percent in the seven (7) year period.[34] Notably, the number of practicing doctors is lower than the total number registered, because the register does not distinguish between doctors who are practicing and those who are not, the total register could include some who are retired, out of the country or inactive.[35] In the Western Cape and in Gauteng, according to the Human Sciences Research Council (HSRC), research indicates that,

> [There] are 14.7 [doctors] and 12.6 physicians per 10 000 people respectively…In Limpopo, there are only 2.1 doctors per 10 000…the inequity of provision in the Western Cape and Gauteng in relation to other provinces is compounded when one considers that most medical aid members are located in these two provinces, each of which has two medical schools with associated tertiary teaching hospitals…[there is a] shortage of doctors in the public service, particularly in the

healthcare workers to R3500 per month." See: Mboweni's National Budget Speech (20 February 2019). Tamar Kahn also says "he struck a practical note;" see Business Day.

[32] *Presidential Health Summit 2018: Strengthening the South African health system towards an integrated and unified health system*, 18.

[33] *Presidential Health Summit 2018: Strengthening the South African health system towards an integrated and unified health system*, 35.

[34] Mignonne Breier, in a chapter entitled, 'Doctors' (Chapter 6) edited by Johan Erasmus and Mignonne Breier (Eds.), *Skills shortages in South Africa: Case studies of key professions* (Cape Town: HSRC Press, 2009), 114.

[35] Breier, 'Doctors,' 114.

rural provinces such as the Eastern Cape, Limpopo and North West.[36]

Mabuza maintains that, "in transforming the healthcare system for the better, the country needs to ensure that there is commitment and appropriately skilled healthcare professionals. According to [the] WHO, one of the six building blocks of a healthy and resilient healthcare system, is the health workforce."[37] The National Youth Policy (NYP, 2015-2020) [a policy issued by the Presidency] also states that, "South Africa needs a skilled labour force to increase economic growth. These skills include…health professionals in different occupational classes to deliver quality healthcare."[38] From a health economic perspective there is a critical shortage of human resources in the healthcare system.[39] Addressing journalists (ahead of his national budget speech) Mboweni said that one of the most pressing issues in South Africa is the poor state of public hospitals, yet "there is nothing difficult about getting a hospital to run properly."[40] He further said the challenge is "management;" and that people must not "get caught up too much in conceptual debates."[41] Management in general and financial management in particular, and other elements of financing the NHI system constitute one major issue that requires further study. Below, I attend to cost implications briefly.

7.4 Cost implications for the implementation of the NHI

7.4.1 Uncertainty of how the NHI will be funded

COSATU (in its Secretariat Report, 2015) has shown that, "[the] overall health expenditure amounted to over R227 billion in 2010"[42] and that, "the current health expenditure in the country exceeds the amount required to introduce the [NHI]. The cost estimates in 2011 amounted to R255 billion by 2012; [R214 billon by 2020 and R255 billion by 2025.]"[43] Yet,

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[36] Breier, 'Doctors,' 114.

[37] *Presidential Health Summit 2018: Strengthening the South African health system towards an integrated and unified health system*, 17.

[38] *National Youth Policy (NYP)* (Presidency: Republic of South Africa, 2013), 40.

[39] Sankara, *Thomas Sankara Speaks*, 263.

[40] Tamar Kahn, 'Provinces to get unspent NHI funds for key posts,' *Business Day* (Thursday 21, February 2019), 9.

[41] Kahn, 'Provinces to get unspent NHI funds for key posts,' 9.

[42] Cosatu, *12th National Congress: Political and Socioeconomic Reports*, Book 2 (Secretariat Report, 2015), 178.

[43] Cosatu, *12th National Congress: Political and Socioeconomic Reports*, Book 2 (Secretariat Report, 2015), 178. The NHI White Paper (2015) confirms that South Africa spent approximately 8.6% of GDP on health services in 2013/2014, with an annual average real increase in spending of one percent (1%) a year over the past three (3) years. In 2015/2016 the public health sector had an expenditure of R173, 062 billion and by comparison, the private healthcare sector had a total expenditure of R177, 873 billion. The private healthcare sector spent more in healthcare expenditure than the public healthcare sector in

according to the National Treasury the health budget was R168.4 billion in 2016/17.[44] R31.9 billion will be allocated for primary healthcare services and R88.2 billion for hospitals.[45] R4.5 billion was allocated to the NHI system over the next three (3) years (2016/2017/2018).

The cost of the NHI system will be influenced by many factors including elements of design and implementation. Therefore, there is no exact number that has estimated the cost of the NHI system. According to the NHI White Paper (2015) to focus on "what will the NHI cost" will be an incorrect approach. Neither is the correct approach based on implications of implementation (scenarios based on the estimates of the NHI pilots). The NHI pilots are not a realistic measure of the roll out or implementation of the NHI system in South Africa. In this regard, the NHI White Paper (2015, 2017) projects that, the total NHI costs in 2025 are shown to be R256 billion (approximately 6.2% of GDP by 2025), and this is a conservative estimation. The costing in the NHI White Paper (2015) is in 2010 terms – modified from the NHI Green Paper (2011) with a moderate cost increase of 6.7% a year (assuming the economy grows at a rate of 3.5%).

A concern is that the NHI policy keeps as an option the impact on costs that includes private healthcare service providers from whom it aims to purchase services. Yet, if the NHI Fund does not purchase services from the private healthcare sector it will save itself an amount to the range of R177, 873 billion.[46] What will escalate costs unnecessarily is exactly this transaction with the private healthcare sector. The NHI White paper (2015) states that, "The private sector health expenditure by medical schemes in 2014/15 was estimated at R139.1 billion. This amount includes preliminary estimates of R20 billion which is the State's contribution to some medical schemes as a subsidy for state employees. *[sic]* (This figure excludes contributions by the state to Polmed, Parmed and State-owned entities)."[47] The R20 billion which is the state's contribution to medical schemes remains a problem. It is a result of

terms of the total percentage of the country's GDP. Of the 8.5% of GDP, 4.4% represents the total healthcare expenditure of the private healthcare sector yet the public healthcare sector spends 4.1% of the total GDP (2015/2016). South Africans spend to the total of R22, 980 billion out-of-pocket in the private healthcare sector. On medical insurance alone there was a total expenditure of R4, 356 billion in the private sector (and on medical schemes there was a total expenditure of R148, 456 billion in 2015/2016). The medical scheme's total expenditure (R148, 456 billion in 2015/2016) alone exceeds the projected NHI expenditure for 2015/2016. The total private healthcare expenditure of R177, 873 billion far exceeds the NHI cost projection for 2015/2016 (R134, 324 billion).

[44] South African Government News Agency (www.sanews.gov.za), retrieved: 15 May 2016.

[45] See South African Government News Agency (www.sanews.gov.za), retrieved: 15 May 2016.

[46] South African Government News Agency (www.sanews.gov.za), retrieved: 15 May 2016.

[47] *White Paper on National Health Insurance (NHI) for South Africa – Towards universal health care coverage,* 48.

the state's maintenance of a two-tiered and fragmented healthcare system.

An analysis of the NHI White Paper (2015) shows that R139, 134 billion (2014/2015) also exceeds the projected NHI Fund expenditure of R134, 324 billion (2015/2016) as an illustrative projection. Then what shall be the actual expenditure commitments? I have argued earlier that the NHI must not purchase services from private providers (whether individual or corporate) but must: *(i)* invest its funds into the current healthcare practitioners and medical professionals in the public sector; and into *(ii)* the development of the skills and expertise that it needs and shall require within the public healthcare sector; and *(iii)* improve the facilities, technology; human resource, and infrastructure of the public healthcare sector. The state must dismantle the two-tiered healthcare system and construct one system. If this is understood, then the implementation of the NHI system will result in the substantive improvement, stability and growth of the public healthcare sector. If the NHI Fund purchases services and products from private providers then the NHI system will contribute to facilitating private healthcare sector expansion at the expense of the public healthcare sector further collapsing. There needs to be a shift away from the use of state funds to contribute to the conglomerate private healthcare sector and all private medical aid schemes and private healthcare facilities including healthcare professionals in private practice. Otherwise NHI financing arrangements will be unworkable. Below, I comment briefly on certain elements of NHI financing.

7.4.2 Elements of NHI financing arrangements

The context in which the NHI policy and legislation is being implemented is a two-tiered healthcare system (I have made this clear in a detailed discussion in chapter 5). As I have shown that in the policy and legislation there are two contextual variables *(a)* public healthcare and *(b)* private healthcare. With such variables in the system what shall be the actual expenditure commitments? The answer to this question remains uncertain. Nonetheless, it has been possible to indicate the broad magnitude of tax changes that might be required.[48] This gives an implicit indication that the NHI would be financed through tax allocations which would be directed towards the NHI Fund. The options that are being explored have to do with raising tax revenue to meet the health expenditure requirement as the phased implementation of the NHI progresses.[49] The financing arrangement for the NHI system is therefore dependent on a tax design (raising tax revenue) that incorporates a tax mix [direct taxes, personal income taxes,

[48] *White Paper on National Health Insurance (NHI) for South Africa – Towards universal health care coverage,* 54.

[49] *White Paper on National Health Insurance (NHI) for South Africa – Towards universal health care coverage,* 48.

corporate income tax, payroll taxes, increasing value added tax (VAT)]. Other arrangements include increasing tax on alcohol and tobacco products, tax on alcohol sales and tax on cigarette sales, wealth tax, property tax, carbon tax, including sugar tax. This imposition of taxes on the population, especially the working-class, becomes grossly inappropriate especially considering that the tax payer's money would also be used to keep the private healthcare sector in business. Unfortunately, as an option for expanding the public funding of healthcare services in both sectors, there are several arguments for favouring an increase in VAT.[50] Financing arrangements for healthcare include: (1) Tax – *(a)* direct/indirect, *(b)* personal income tax, *(c)* value added tax [VAT], *(d)* borrowing;[51] (2) Social insurance – *i.e.* via proportional payroll contributions/taxes;[52] (3) Private insurance – *i.e.* medical schemes;[53] (4) User fees – *i.e.* out-of-pocket payments;[54] (5) Community financing; and (6) Donations/grants. With regards to

[50] *White Paper on National Health Insurance (NHI) for South Africa – Towards universal health care coverage*, 48. This may contribute further to the increase in food prices.

[51] The NDP (2012) elaborates that, "Private health insurance is a source of financing for healthcare in many countries, particularly those with advanced National Health Service systems (the United Kingdom [UK], Sweden, Spain and Italy). Types of taxes that underlie general tax income include personal income tax; value added tax and company tax. Taxes on alcohol and tobacco also contribute to the general revenue pool;" and that, "General taxation tends to be effective and equitable. In South Africa, the South African Revenue Service [SARS] is a competent national revenue authority. Personal income tax is a particularly progressive form of raising revenue: the level of income determines the amount of the tax, and the poorest are not taxed. It is more progressive than collecting comparable resources through NHI contributions. These are based on fixed contributions according to the requirements of the NHI and not on income. Value added tax (VAT) is a key source of general tax in most countries. In many countries with universal health care systems, VAT is at a higher level than in South Africa. However, no firm decision has been taken on including VAT as a source of funding for the NHI" (p.344).

[52] According to the NDP (2012) "Social health insurance contributions are typically mandatory, linked to income (typically as a percentage of income) and not risk rated. They are therefore more progressive than private schemes, although they typically provide a limited set of benefits. Payroll taxes are the predominant source of funding for NHI in some countries. However, once coverage becomes universal, the advantages of payroll taxes against general taxes become less significant and the more progressive nature of general taxes make them preferable" (p.344).

[53] The NDP (2012) further notes that, "Private health insurance is not an effective system for financing universal healthcare: it is voluntary, uses risk rating (meaning that some people may be excluded or charged prohibitive fees), excludes many people, and contributions are not linked to income. An additional consideration is that South Africa's medical schemes are not typical private health insurance vehicles and have already been through several sets of reforms. They are non-profit entities and risk rating is prohibited;" and that, "Medical schemes in South Africa are a well-established financing mechanism used by 8.3 million beneficiaries. Occupationally linked restricted medical schemes cover 3.1 million beneficiaries and have gross contributions of R37 billion in 2010/11" (p.344).

[54] The NDP (2012) holds a position that, "(out-of-pocket payments) are a regressive form of health financing and can seriously detract from access to health services. Out-of-pocket payments should not constitute more than 15 to 20 percent of health financing revenue to minimise the risk of health costs seriously compromising a household's finances. In South Africa, user fees contribute about 8 percent of revenue, mainly for private services. The public sector derives only 1.8 percent of its expenditure from user fees and has exemptions for various groups. *One view is that there should be no user fees at all* (with

financing the NHI system using such options, there are aspects within this arrangement to which I do not agree with. [Healthcare financing requires further studies]. For example, in a congress report, Cosatu states that,

> Neoliberal supporters within and outside government have also suggested methods of financing that defeat the logic of introducing [the] NHI. These include co-payments, financing through Value Added Tax (VAT) and multi-payer systems. All the above-mentioned payments will place an extra financial burden on citizens when accessing healthcare. The primary aim of the [NHI] is [to] entrench free healthcare at the point of service. According to the Green Paper (2011), there will be co-payments and [there are] investigations on the possibility of introducing multi-payer systems. [Treasury] is silent on the question of using VAT. Treasury is primarily responsible for making the final decision on financing the NHI. Informal reports suggest that [Treasury] wants to use the above-mentioned methods of financing.[55]

I concur with Cosatu. The financing arrangements that Cosatu has numerated above defeat the logic of introducing the NHI system. There should be no co-payments and user fees charged in a free healthcare system and out-of-pocket payments need to be eliminated. Cosatu is correct. At its 11th national congress (as recorded in its Secretarial Report 2015), Cosatu took resolutions that: (1) The NHI system must be funded via the general revenue, taxes and high-earning self-employed individuals, payroll linked progressive contribution tax, tax on high earning individual taxpayers and contribution by employers; (2) There must be no additional levies through VAT; (3) There must be no co-payments as those who can afford to pay will have paid through employee taxes; (4) Tax subsidies to the private sector must be ended; (5) The NHI Fund must be publicly-funded and administered with no outsourcing of administration; (6) There must be no investigation into multi-payer systems.[56] Moreover, public healthcare services offered to the black majority in general, and Africans in particular, that have deteriorated currently run the risk of complete collapse. An imperative is that the NHI system must be established with the NHI Fund as a single-payer and single-purchaser fund

minimal exceptions, such as for non-South Africans and services outside the package). Another view is that user fees play a role in controlling unnecessary demand for discretionary services, and this contributes to avoiding catastrophic household health expenditure (defined as more than 40 percent of non-food household expenditure)."

[55] Cosatu, *12th National Congress: Political and Socioeconomic Reports,* Book 2 (Secretariat Report, 2015), 178.

[56] Cosatu, *12th National Congress: Political and Socioeconomic Reports,* Book 2 (Secretariat Report, 2015), 178.

responsible for the pooling of funds and the purchasing of healthcare services for the population in the public sector. Sufficient resources must be channeled into the public healthcare sector only which largely serves the poor and working-class majority.

7.4.3 Financing the NHI system towards implementation

According to Cruywagen, towards the implementation of the NHI system, healthcare and education will receive the lion's share of the spend in the Western Cape's total budget expenditure of R67.14 billion in what Finance MEC Ivan Meyer called a "consolidation for maximum citizen impact."[57] The Western Cape provincial government would spend R24.757 billion (37%) of its budget on healthcare (and R23.669 billion on education).[58] But corruption in the two-tiered healthcare system is rife, and the education system is in a crisis. Bonitas Medical Fund chief operating officer said Bonitas recovered R31.2 million in 2018 and had three criminal convictions of private healthcare practitioners (clinical psychologist, audiologist, and a GP) for fraud and contravention of Section 66 of the Medical Schemes Act.[59] About R10 billion was lost to fraud and abuse in the private healthcare system.[60] However, according to Kahn, an extra R1 billion has been added in 2021/2022 to fund the permanent appointment of interns, with an additional R1 billion to improve pay for community healthcare workers and bring their remuneration in line with the minimum wage.[61] Kahn maintains that consolidated health expenditure is set to increase from R208.8 billion in 2018/2019 to R222.6 billion in 2019/2020, and will then rise to R238.8 billion 2020/2021 and to R255.5 billion in the outer year.[62] Additionally, there are trends in abuse in the private healthcare sector – lack of practice numbers or applications for multiple practice numbers; fraudulent behavior reported to the HPCSA; fraudulent pharmacies; emergency services vehicles used for general transport but claims submitted as if members had an emergency; mark-ups up to 300% being added to poor quality devices supplied by practitioners; falsified invoices; and syndicate related fraud. Speaking at a media briefing, National Treasury Director-General Dondo Mogajane said the challenges for the NHI system were identifying where the state funding would come from for

[57] Vincent Cruywagen, 'Education, health get lion's share: 'consolidation for maximum citizen impact,'' Cape Argus (Wednesday, 6 March 2019), 1.

[58] Cruywagen, 'Education, health get lion's share: 'consolidation for maximum citizen impact,'' 1.

[59] A staff reporter at Cape Argus reported this in an article entitled, 'Health scheme fraud now rife,' Cape Argus (Wednesday, 6 March 2019), 7.

[60] Cape Argus, 'Health scheme fraud now rife,' 7.

[61] Kahn, 'Provinces to get unspent NHI funds for key posts,' 9.

[62] Kahn, 'Provinces to get unspent NHI funds for key posts,' 9.

a successful implementation of the NHI system in such a context.[63] Serfontein also asserts that,

> The state of the nation address and recent launch of the presidential health summit report has only added to the uncertainty surrounding the NHI model and is still failing to address pragmatic issues surrounding the funding of the behemoth, such as what it will cost and how the state will render services within the NHI context.[64]

In view of the above quotation, according Mogajane, there were a number of factors to be looked into.[65] The NHI system had been funded via the NHI indirect grant and the health component in the province's Equitable Share.[66] Mogajane put the baseline for the NHI system in the medium-term expenditure framework at R4.3 billion.[67] According to him, existing money will be diverted into the NHI programme once it is rolled out.[68] Kahn has noted that the NHI indirect grant is allocated an extra R1.4 billion over the medium term to build a new academic hospital in Limpopo and improve tertiary hospitals in the province. The Treasury has also restructured the comprehensive HIV, Aids and Tuberculosis (TB) grant to include malaria and community outreach programmes. The largest part of this grant is directed to HIV/Aids programmes.[69] The Treasury had stated in its Budget Review that, "Implementing [the] NHI is a policy priority...However, the government needs to address staff shortages and other problems in public health facilities before the policy can be fully rolled out."[70]

In this context, president Cyril Ramaphosa in his state of the nation address (7 February 2019) said that, "by introducing the [NHI system], together with a multipronged quality improvement programme for public health facilities, we are working towards a massive change in the health experience of South Africans."[71] Reiterating Ramaphosa's position, Mboweni affirmed that the priority for public healthcare services was to ensure it functioned properly.[72] Hence Mboweni insisted that, "We need to manage properly. We need to make sure that people [do not] steal

[63] Maqhina, 'R4 billion allocated to NHI,' 1.

[64] Johan Serfontein, 'Looming NHI disaster would dwarf Eskom blowout,' *Business Day* (Thursday 21, February 2019), 13.

[65] Maqhina, 'R4 billion allocated to NHI,' 1.

[66] Maqhina, 'R4 billion allocated to NHI,' 1.

[67] Maqhina, 'R4 billion allocated to NHI,' 1.

[68] Maqhina, 'Filling health posts key in NHI roll-out,' 4.

[69] Kahn, 'Provinces to get unspent NHI funds for key posts,' 9.

[70] Kahn, 'Provinces to get unspent NHI funds for key posts,' 9.

[71] Serfontein, 'Looming NHI disaster would dwarf Eskom blowout,' 13.

[72] Maqhina, 'R4 billion allocated to NHI,' 1.

medicine from pharmacies."[73] At the presidential health summit launch, former health minister Aaron Motsoaledi confirmed, according to Serfontein, that there was a "war room" which brought together key departments to address the crisis in the public health system while preparing for the implementation of the NHI system.[74] Motsoaledi also said that, "We are guided by the insight that improving the health system and introducing [the NHI system] are two sides of the same coin [that] are mutually reinforcing."[75] Motsoaledi's sense is that these processes (private and public) will run in parallel and that this would strengthen state healthcare services available to public healthcare users of state facilities. But this may not be the case.

The Budget document said that the R2.4 billion allocated over the medium-term expenditure framework would fund initiatives that strengthened healthcare systems, including information systems, ideal clinics and centralised dispensing and distribution of chronic medicines.[76] This will enable the department to, by 2020-21, implement improved web-based health information systems targeting 3702 health facilities.[77] Moreover, because of slow spending in the personal services component of the grant, R2.8 billion had been prioritised to enable provincial departments to fill critical posts in health facilities.[78] Various provinces have unfilled vacancies in the Department of Health. The Treasury has shifted unspent NHI funds to provinces so that they can fill critical posts. This is a pragmatic move to tackle one of the most pressing problems confronting public healthcare (HRH).[79] This leaves the personal services component with allocations of R2.3 billion over the medium term to fund priority services for the NHI system.[80]

The NHI Bill (2018) states clearly that the NHI Fund will only contract with facilities accredited by the office of health standards compliance (OHSC).[81] This creates ambiguity, as the last OHSC inspection results indicated that only six [6] of 696 inspected public facilities passed quality inspections; this would leave 690 facilities unable to contract with the NHI Fund or deliver services to South African citizens within an NHI environment.[82] Mabuza concurs

[73] Maqhina, 'R4 billion allocated to NHI,' 1.

[74] Serfontein, 'Looming NHI disaster would dwarf Eskom blowout,' 13.

[75] Serfontein, 'Looming NHI disaster would dwarf Eskom blowout,' 13.

[76] Maqhina, 'R4 billion allocated to NHI,' 1.

[77] Maqhina, 'R4 billion allocated to NHI,' 1.

[78] Maqhina, 'R4 billion allocated to NHI,' 1.

[79] Kahn, 'Provinces to get unspent NHI funds for key posts,' 9.

[80] Maqhina, 'R4 billion allocated to NHI,' 1.

[81] Serfontein, 'Looming NHI disaster would dwarf Eskom blowout,' 13.

[82] Serfontein, 'Looming NHI disaster would dwarf Eskom blowout,' 13.

that, "As South Africa plans to introduce [the NHI system] in a phased approach from 2019, incrementally, certification of health facilities is required to meet the standards set by the Office of Health Standards Compliance, followed by accreditation of NHI by the NHI Fund."[83] But, according to Serfontein, 2 600 state facilities were not inspected in 2017.[84] If similar quality prevails in these facilities there would be 30 public clinics and hospitals qualifying to contract with the NHI Fund and render NHI services.[85] It is therefore inconceivable that the NHI system can be implemented without a radical, comprehensive quality improvement programme in the public healthcare sector preceding it.[86] It makes little sense to indicate that these processes (private and public) will run in parallel, as this would create a major shortage of state healthcare services available to public healthcare users.[87] Even though I concur with most of Cosatu's ideas about the NHI system, I have a sense that Cosatu has not given the proposed NHI policy and legislation sufficient scrutiny. Otherwise they would have opposed it in its current format.[88] By contrast, Mboweni supports the current framework of the NHI system. Mboweni used his address before Parliament to announce more allocations towards the NHI system.[89] He announced that R2.8 billion had been allocated to a new human resource grant and another R1 billion for medical interns.[90] Echoing this Kahn maintains that,

> The Treasury has moved R2.8 [billion] out of the NHI indirect grant over the next three years to fill critical public healthcare posts, including interns and community service positions. This will be achieved through a new human resource capacitation conditional grant, which means the funds are ring-fenced and provinces cannot use them for other purposes.[91]

Kahn further points out that the NHI system's indirect grant includes programmes for mental health, school health and contracting with private sector GPs.[92] According to the Treasury's chief director for health and social development Mark Blecher, Kahn affirms that, barely 10%

[83] Presidential Health Summit Report (2018), 17.

[84] Serfontein, 'Looming NHI disaster would dwarf Eskom blowout,' 13.

[85] Serfontein, 'Looming NHI disaster would dwarf Eskom blowout,' 13.

[86] Serfontein, 'Looming NHI disaster would dwarf Eskom blowout,' 13.

[87] Serfontein, 'Looming NHI disaster would dwarf Eskom blowout,' 13.

[88] Serfontein, 'Looming NHI disaster would dwarf Eskom blowout,' 13.

[89] Maqhina, 'Filling health posts key in NHI roll-out,' 4.

[90] Maqhina, 'R4 billion allocated to NHI,' 1.

[91] Kahn, 'Provinces to get unspent NHI funds for key posts,' 9.

[92] Kahn, 'Provinces to get unspent NHI funds for key posts,' 9.

of the R2.3 billion allocation for 2018/2019 had been spent by October (2018) and spending had remained slow since then.[93] Mboweni stated that R1 billion has been added to raise the wages of community healthcare workers to R2500 per month, further adding that R317 million was allocated to eliminate malaria in South Africa.[94] Additionally, Kahn suggests that the Treasury has set aside R75 billion for HIV/Aids conditional grants over the medium term. The malaria component of the grant is allocated R318.8 million over the next three years, which is intended to combat malaria in the most affected provinces: Mpumalanga, Limpopo and KwaZulu-Natal. Part of the funding is intended for a project with the Mozambique government and the Bill and Melinda Gates Foundation.[95] Mboweni concluded that the health services needed simple, effective interventions.[96] More than R4 billion has been allocated to fund initiatives aimed towards the NHI system over the next three financial years.[97] According to Serfontein, the NHI Fund will be twice the size of national power utility (Eskom).[98] An impact evaluation of the implementation of the NHI system in a two-tiered healthcare system over the next three years will need to be done. Such an evaluation remains a future study.

7.5 Conclusion

In this chapter, I provided an analysis of the NHI system's focus and central approach that of using Community Health Care Workers (CHWs) in the strategic reengineering of primary healthcare. I also discussed *(i)* a variety of arrangements for the financing of the NHI system, *(ii)* human resource development for health, *(iii)* a policy framework for the NHI system's integral strategy of primary healthcare reengineering including *(iv)* an evaluation of the impact of implementing the NHI system in the next coming years towards 2025. In the next section, I offer concluding remarks followed by a reflective critique.

[93] Kahn, 'Provinces to get unspent NHI funds for key posts,' 9.

[94] Maqhina, 'R4 billion allocated to NHI,' 1.

[95] Kahn, 'Provinces to get unspent NHI funds for key posts,' 9.

[96] Maqhina, 'R4 billion allocated to NHI,' 1. *Cape Argus* published the same view on the same date, on page 4. Maqhina quotes Tito Mboweni in his budget speech. The speech published in the Cape Times (p. 21 and p.21).

[97] Maqhina, 'R4 billion allocated to NHI,' 1.

[98] Serfontein, 'Looming NHI disaster would dwarf Eskom blowout,' 13.

Concluding remarks on the NHI system

The South African government has issued out policies and legislation to implement the NHI system and more crucially its sub-system the NHI Fund. The NHI policies (Green Paper and White Paper) create the NHI system to implement UHC. However, the NHI Bill (2018) establishes the NHI Fund to enable strategic purchasing in both the private and public healthcare sectors. In this regard, Chapter 1 introduces the study. It provides a background and the research problem. In it, the research question is articulated including the sub-research question. The central research question was: to what extent do the neoliberal ideological systems that underpin the NHI policy and legislation ensure the realization of universal access to free quality healthcare for the poor and the working-class in South Africa? The study has shown that an NHI system that is underpinned by neoliberal ideology will seek to offer free healthcare to all through private healthcare sector institutions, thereby deprioritizing the public healthcare sector. Neoliberalism, in this context, needs to be confronted and an alternative ideology provided, if all people, especially the majority, in South Africa are to receive free quality healthcare.

The sub-research question in the study was: to what extent should the private healthcare system financially benefit from the NHI Fund? It may be the case that the private healthcare sector needs to be negated in the entire system, and that it should not benefit from the NHI Fund. Healthcare is a use-value, not a commodity that should be traded in the market system. It should be de-commercialized and offered by the state *only*. The private healthcare sector needs to be brought into the legal ownership of the state, if it is to benefit from the NHI Fund. I provided a hypothesis that the development of a policy and legislation to manage a two-tiered healthcare system may affect the NHI system negatively. If the NHI system is implemented in its current framework (in collaboration with the private healthcare system) then the private healthcare system may not make a positive contribution to the public healthcare system as assumed. It is my view that co-opting the private healthcare sector to implement the NHI system will lead to an unregulated expansion of the private healthcare system. The private healthcare sector, in commercializing healthcare, will seek to maintain rising market related costs in accordance with the market system.

The study aimed at analyzing the ideological systems that underpin the NHI system; and to show that there are ideological contradictions in offering free, universal, quality, state

healthcare services in South Africa using the private healthcare system for delivery. This required identifying the ideological framework in which the NHI system is framed in its policy and legislative context and an analysis of the ideological systems, principles, concepts, and sub-concepts that underpin the NHI system.

In order to address the questions that have been raised in the study, Chapter 2 set out a theoretical framework in terms of which the research questions were clarified and the substantive issues examined. In it, I explained the methodology to be used in evaluating and analysing the situation regarding the NHI system's linking of the private healthcare sector to public healthcare provision. I explained that there is a complex interaction between the private and public healthcare systems. I considered two possible methodologies that are related to the ideologies that underlie private and public healthcare provision. I compared a human rights-based approach (HRBA) and Marxism. As a result, the chapter has two main sections. In the first section, I gave a brief historical background to human rights which has links to liberal ideology and considered the main components and the principles of a human rights-based approach (HRBA) as a methodological framework for examining the NHI system. I have reservations regarding the HRBA as a methodological option. I hold that reliance on the HRBA underplays a critical analysis of the complex relationship between the two healthcare sectors in the South African context. I discussed Marxist principles and then provided a comparison between Marxism and the HRBA. I then showed how both methodological approaches work in practice and also showed that a methodology emerging from the analysis of Marxist principles is more suitable to the present study. However, race dimensions in South Africa complicate the matter. To this complication, I add the dimension of *dialectic* (which is difficult to include) though I am aware that Marxism does not deal with racism adequately.

In order to provide the necessary data, Chapter 3 provided a historical account of the ideological debates within the ANC and SACP regarding the nature of the struggle and the unfolding thinking on the healthcare system. It gave background to the historical and ideological origins of privatization of healthcare in South Africa. It showed that towards the democratic transition the apartheid government privatized the healthcare sector and introduced free market-based principles into the healthcare economy. Most importantly, I showed that the idea of healthcare provision being the responsibility of both the public and private healthcare sectors pre-dates 1994. Chapter 3 further shows that in the 1990s a debate raged within the ANC regarding its strategic objective. Key to the debate was the question of the *two-stage theory* of the National Democratic Revolution (NDR). The debate was unresolved. In this regard, I provide an

alternative epistemology to the ANC's political theory. I use the healthcare system as a test case. My methodological perspective is Marxism. I keep this framework in mind as I present a historical account of the ideological debates in the ANC.

Almost as a continuation of Chapter 3, Chapter 4 traced the historical evolution of the NHI policy and legislation within the policy shifts in the ANC in the democratic period. I kept in mind the underlying philosophical basis and affirmed that there are two competing healthcare systems that survive ANC policy shifts. I located the discourse on the NHI system in the historical policy shifts within the ANC. I showed that two healthcare systems developed in opposition to one another: one private (to service the minority) and the other public (to service the majority). However, I also showed that there were forces pushing the economy towards a more socialist system. Such forces were calling for an overhaul of the two-tiered healthcare system and for the NHI system to be phased in. I noted that the concept of the NHI system can be traced back to the democratic transition period during 1994. However, the concept of free healthcare for all in a *unified* healthcare system emerged during 1997.

In view of Chapters 3 and 4, Chapter 5 offered a reflection and an analysis of the contemporary situation on the NHI system. Essentially, it is a discussion of the NHI policy and legislation. It also introduced the Medical Schemes Amendment Bill (2018) which was issued out simultaneously with the NHI Bill (2018). The purpose of the discussion is to raise the question: can the NHI system and legislation bring about the stated goal? I argued that it cannot because of the contradictions – in Marxist terms – between treating healthcare as a use-value and as a commodity. I showed that the NHI legislation establishes the NHI Fund as a financing (strategic purchasing) and implementing mechanism of the NHI system that will purchase healthcare in both the private and the public sectors. My aim was to show that there is a tension in the NHI policy and legislation which inevitably arises because the private and the public sectors are contradictory (and not complimentary). Therefore, I argued that a clearer policy must be articulated to resist the option to purchase healthcare in the private sector using the NHI Fund. Additionally, I also argued that the NHI legislation may require reformulation and be re-written in such a way that insists that healthcare is not a commodity; thereby making a case for its complete decommodification and decommercialization – so that it is offered for free by the state *only* in a single tier.

Having shown the establishment of the NHI Fund as a sub-system of the NHI system; and argued that the NHI Fund may have taken a neoliberal ideological posture by setting out to purchase healthcare in the private healthcare sector; in Chapter 6, I compared competing

ideologies: neoliberalism (as an ideological paradigm for privatisation, private ownership and control) and socialism (as an ideological paradigm for nationalization, state ownership and control). These are ideological systems (paradigms/meta-theories) that underpin the two healthcare sectors. I showed that these ideological systems compete and do not complement each other. I also showed how the two ideologies relate to the two healthcare sectors (and to the issue of a one-tier or two-tier system). I addressed the ultimate question of whether the NHI system is likely to provide a just/equitable healthcare system. I considered the two competing ideologies in relation to the ongoing discourse and to the latest proposals on the NHI system. I used Marxism as a framework to analyze the two healthcare sectors (private and public) as complex systems and showed that the two sectors have a complex interconnectedness.

Moreover, I analyzed the tensions and differences amongst the various ideologies and reflected on their status in healthcare discourse. The focus was on a philosophical analysis of the ideological systems that underpin the NHI policy and legislation and to determine whether there shall be *free* healthcare "at the point of care" for all in a *unified* system upon the implementation of the NHI system. Chapter 6 does not focus on the healthcare system (proper), but ideological systems. In my analysis, there is an ideological contradiction within the NHI policy/legislation. This contradiction is potentially a very powerful source of systemic change. However, such a contradiction also locates itself within neoliberal capitalism.

Towards the conclusion, and in seeking to answer basic questions regarding healthcare financing and primary healthcare re-engineering, Chapter 7 explored primary healthcare re-engineering as an integral aspect of the NHI policy and legislation. It integrated an element of financing arrangements in the national implementation of the NHI system. It offered an account of the strategy for primary healthcare re-engineering including how the NHI will be funded. It also included relevant policy documents in this regard. Chapter 7 also provided an overview of primary healthcare reengineering and NHI financing in the public healthcare sector. Also, it offered a discussion of a development strategy for human resource for health (HRH) as an imperative in the sustainability of the NHI system.

I recognize at the end of the study that healthcare system financing remains an element that requires further research. Moreover, race, class, income, and location are still important social determinants for access to public and private healthcare services in South Africa.

To offer conclusion remarks it is important to note that African people residing in poorer provinces (in informal settlements, townships and rural areas) utilize public healthcare services

as opposed to private healthcare services. The end of apartheid has not seen an end to all of the inequalities. Many inequalities still exist and are strongly influenced by socio-economic factors such as class and income. Particularly, in South Africa, race, class and income remain inextricably linked. The private healthcare sector does not play a complementary role to the public healthcare system, it collapses it. With the introduction of the NHI system, medical aid schemes should not be permitted to continue to act as the main financial intermediaries in the healthcare sector. The private and public healthcare sectors do not complement one another. Moreover, the private healthcare sector benefits from the human resources of the public healthcare sector, thereby further collapsing the public healthcare system. It sets up a skills migration from the public healthcare sector to the private healthcare sector.

It may be the case that the South African government may need to nationalize the private healthcare system if it is to benefit from the NHI Fund. Nationalization does not mean ending with fully taxpayer-funded state-owned healthcare services; nationalization is the process of transforming private assets into public assets by bringing them under the public ownership of the national government. The private healthcare sector in South Africa may need to be subjected to nationalization. Healthcare services and facilities cannot continue to be privately owned. The government's healthcare plans may need to continue in the direction of nationalization. This must remain the ultimate goal. Therefore, healthcare in South Africa may need to be offered for free thereby decommercialized. The South African government may incessantly pursue the nationalization of the conglomerate private healthcare sector. Private hospitals and private clinics, including private pharmacies, and private ambulance services, private healthcare related laboratories, *etc.* need to be brought into the legal ownership and control of the democratic state.

The private healthcare sector is currently very expensive to maintain as a private industry and it is financially inaccessible for the majority of the population. Thus, it needs to be left to its own devices and must not be bailed-out, assisted, contracted, or subsidized any longer with government funding. The private healthcare sector is profit-oriented and focused on profit maximization; it involves a network of private businesses that offer private healthcare and healthcare related services to private clients. The democratic government offers public healthcare services. It does this without using private sector healthcare institutions. To do this (offering public healthcare services using private sector healthcare institutions) shifts its focus and strategic resources from improving the public healthcare sector facilities and offering free quality services to all in the population. If the government offers free public healthcare services

by incorporating private sector healthcare institutions, then this action will compromise the revolutionary aspect of the NHI system. This compromise may lead to the implicit defense of keeping the private healthcare sector and the two-tiered healthcare system intact, and offering indirect support for the expansion of the private healthcare sector using public funds. To reiterate, for the private healthcare sector to receive any money from the NHI Fund, a strategy for its nationalization may be required. The private healthcare sector has to be appropriated, owned, and controlled by the government through the NHI system as a mechanism and the NHI Fund as a vehicle for appropriation, ownership, and control. This strategy will assist towards price regulation and ensuring that prices are standardized for every facility that offers healthcare services in South Africa. If this is done, then the ANC may defend the political, ideological, and revolutionary concept of free healthcare for all at the point of care/service without any ideological concerns/confusion.

The NHI Act should articulate clearly that there is a case for private healthcare sector facilities that will work with the NHI Fund to be subject to nationalization. The private healthcare sector maintains inequalities within the healthcare system and protects minority and monopoly interests at the expense of the majority who are working-class and poor. Private doctors, including those that are practicing in "surgeries" (within the townships), and specialists that seek to have their services purchased through the NHI Fund may need to agree to offer their services within public healthcare sector facilities. This may prevent the negative skills migration and decanting of state patients to the private sector. To receive payment from the NHI Fund, healthcare professionals and practitioners may be required to function within the public healthcare system in appropriate government facilities. This can be legislated and made mandatory. The South African government may offer free public healthcare services without incorporating private healthcare institutions. All inputs into the public healthcare sector such as drugs and medicines *etc*. the government may create state-owned companies that shall supply the needs of the public healthcare sector. The purchaser-provider-split is unnecessary. Integral to the success of the NHI system is the issue of skills and expertise that are relevant to the healthcare sector such as doctors, nurses, paramedics, dentists, physiotherapists, *etc*. There needs to be a design and development of a strategy for the training and retention of skilled personnel in the country that will maintain the proper functioning of the NHI system and its objectives within a nationalized healthcare system.

Public healthcare facilities can be improved with proper infrastructure, appropriate technology and with staff that can be remunerated adequately using the NHI Fund as a mechanism. The

conglomerate private healthcare sector, if it chooses to continue to operate, can increase its costs as it pleases and whosoever wants to access its services can do so at their own financial peril. The South African government should focus all its resources (allocated towards the healthcare sector) for the improvement of the public sector *only*; so as to improve the standard of public healthcare sector facilities to be above that of the private healthcare sector. This is possible if the government takes away from the private sector its funds that it invests towards the operations of the conglomerate private healthcare sector.

The joint position that should be held by the ANC, SACP, and Cosatu is that the free market system in the national healthcare system must be rolled back and that private profit interests must not be permitted to operate within the healthcare system. If the ANC-led tripartite alliance claims to be a disciplined force of the left with a bias to the interests of the working-class and the poor, then healthcare must not be treated as a commodity to be traded in the free market system. Engineered appropriately, and implemented in a way that is public healthcare sector focused, the NHI Fund may ensure that there is no such thing as "private hospitals" in South Africa, given the high levels of inequalities within the healthcare sector. It may be a moral imperative that South Africa move towards *one* national healthcare system, a *unified* healthcare system that is state-owned and that provides hospitalization *for free* and *for all* at the point of care/service. The current dichotomous and unsustainable concept of an unequal, fragmented, and expensive high-quality private healthcare system for the minority may need to be done away with. Below, I offer my final reflective critique on the NHI system. I depend on Phadu and Thulare's joint Cosatu-SACP presentation for my critique.

Reflective critique on the National Health Insurance (NHI)

I offer my final reflective critique on the NHI system. I depend on Phadu and Thulare's joint Cosatu-SACP presentation for my critique. The National Health Insurance (NHI) in its current design appears to be a socialist system, but in reality, it is not. Nevertheless, the NHI system should be understood from a class perspective.[1] Phadu and Thulare assert that,

> Marxism teaches us not only to see reality based on race and gender, but more fundamentally based on class. Class and therefore relations of class power are important categories for understanding our society and its health system. How people live, get sick or die depends not only on race and gender but primarily on which class [one belongs to].[2]

In my view, relations of race and class power are important categories in South African society and its healthcare system. Phadu and Thulare, as members of the ANC, are aware that there is an interiorization of race into class in South Africa. In this context, the NHI system has been proposed by the South African government as a health financing system. It is designed to pool funds to provide access to quality affordable healthcare for all South Africans irrespective of

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[1] Comrade (Cde) T. Phadu and Cde A. Thulare, presented slides entitled: *'For a working class-led NHI campaign'* in a joint SACP-COSATU workshop in Gauteng. The slides from the presentation were not paginated. I received the 21 slides on 23 August 2020. We were 6 months into the Lockdown due to the Covid-19 pandemic. In South Africa the government was at the forefront of the Covid-19 response. In its response and with a country of close to 60 million people, South Africa became an example to the WHO. But during the pandemic, the private healthcare sector became the biggest financial beneficiary. To add a German context on Phadu and Thulare's class perspective: almost a century ago Prince Otto Eduard Leopold von Bismarck, the principal creator and first chancellor of the new German nation-state, introduced a compulsory National Health Insurance (NHI) system to the Western world. Since the introduction of the NHI system in Germany, various nation states have followed Bismarck's lead. Today, almost every developed country has an NHI plan. Currently, Publicly-Funded Healthcare Insurance (PFHI) in Germany is provided by the public Statutory Health Insurance (SHI) scheme. In the German context, the concept of the SHI system has brought about the interconnection of various conceptual and economic categories. For example, class as a conceptual category is the ruling material force of German society. The class which owns the means of healthcare production has control of the healthcare system. However, the German healthcare system has undergone a series of recent and controversial changes, implemented to improve competition within the healthcare sector and reduce its spiraling cost to the government. In Germany, healthcare is a commodity that is traded (exchanged) in the market system. German citizens are insured on a per family basis. In this context, commodified healthcare is an element of capitalist healthcare production systems. Hence, financing the SHI system continues to be a challenge for Germany.

[2] Phadu and Thulare, 'For a working class-led NHI campaign.' This workshop presentation was occurring within the context of the Covid-19 pandemic. After South Africa had experienced its initial Covid-19 cases, it went into Lockdown (Level 5) on 26 March 2020. At the time of writing this reflection, the country had eased Covid-19 restrictions and had moved to Lockdown Alert Level 1. The number of fatalities due to Covid-19 has breached the 20 000 mark. There were more than 700 000 Covid-19 cases. Covid-19 had become a serious healthcare security threat.

their socioeconomic status and background. Unfortunately, there is an operative neoliberal ideological rationale in the means of implementation of the NHI system. Thus, the current NHI system's framework that is designed to ensure the realization of universal access to free quality healthcare for the poor and the working-class is underpinned by a neoliberal ideological system.[3]

In the presentation to a joint Cosatu-SACP meeting, Phadu and Thulare, noted that, "We therefore need to study the social, economic and political forces (in short, the class forces) that shape our society, and shape its health sector – including its organisation and funding."[4] In our society, a race and class-based society, the forces that shape our healthcare sector are neoliberal forces. Neoliberalism presents a problem as an ideological foundation of the proposed NHI system. Underpinned by a neoliberal ideological system, the healthcare system is framed and measured by economic terms. In this sense, neoliberalism is a particular form of reason that reconfigures the healthcare system this way.[5] Though the NHI system is presently undergoing

[3] In China, class has been defined by specific historical antagonisms within the social production process. As a result, China had a cooperative approach to medical schemes initially. Such cooperative healthcare schemes were managed by communes. However, this changed over time. The Chinese workers, government employees, including owners of enterprises organized labour-based medical insurance systems that covered also their families. It is this system that forms a foundation for the national insurance system known in China as the Government Insurance System (GIS). China was strategic in dealing with the Covid-19 pandemic. Under the leadership of Xi Jinping, the Chinese government was able to build a specialized hospital for Covid-19 patients in less than 10 days as a strategy for containment. They successfully contained the viral outbreak that had first emerged in Wuhan.

[4] Phadu and Thulare, 'For a working class-led NHI campaign.' Furthermore, they hold that, "The contributions to this meeting should help us to understand what we are up against but what we are for – the national health insurance for a universal health system." At this time the country was up against a virus that was killing people irrespective of race and class. The Covid-19 pandemic provided an added rationale for the implementation of the NHI system. When the viral outbreak reached South Africa every person in the population needed free healthcare provision. Covid-19 testing in the private healthcare sector, for example, was expensive for the working-class and inaccessible to the poor masses. For critical Covi-19 cases, accessing Intensive Care Unit (ICU) beds and receiving oxygen ventilation became expensive and accessible to a minority that could afford it; yet, Covid-19 affected everyone, irrespective of whether one could afford healthcare or not.

[5] Wendy Brown, *Undoing the demos: neoliberalism, stealth revolution* (New York: MIT Press, 2011), 10. Complexity is perhaps the most essential characteristic of the American healthcare system. The United States (US) is an unequal and divided society. It is divided by race, class, ethnicity, income, location, and property relations. In such a society, there are racialized inequalities of wealth and power. The inner contradiction of American society is that it is dominated by the neoliberal paradigm of privatization. Hence, within the healthcare system the ultimate goal of a society that is underpinned by neoliberal ideology is the *private ownership* (one element of the system) of the main means of healthcare production. The US, a neoliberal country, by the time of completion on this PhD dissertation, had become the epicentre of the global Covid-19 pandemic. Global Covid-19 cases had reached over 52.7 million cases and a total of over 1.2 million Covid-19

a phased implementation in South Africa as a means to achieve Universal Health Coverage (UHC), its implementation presents an urgent problem to address due to the complex challenges of access to healthcare.[6] According to Phadu and Thulare,

> [To] strengthen [the] current struggle to introduce [the] NHI through policy and legislation – the release of the NHI Bill is a case in point. Let us also salute [Cosatu] and its affiliates and SACP structures for active engagement and [mobilization] during NHI public hearings…But while the Bill is before parliament, we should continue to be vigilant [against the] National Treasury's policies of neo-liberal austerity (cutting health budgets and shifting NHI resources to increase privatisation of health).[7]

The NHI system involves the introduction of a new variable: the NHI Fund, as a subsystem, established by the NHI Bill to be an implementing mechanism for the entire healthcare system, within a framework of the National Treasury's policy of neoliberal austerity. Phadu and Thulare point out that, "These policy demands have been more generally endorsed since [the] 2007 ANC Polokwane Conference resolution, reflected in [the] ANC Election Manifesto and have been carried forward into government in [the] form of the NHI Bill."[8] Within this neoliberal policy and legislative context, the NHI Bill is before Parliament. In my view, seeing that the NHI Fund is new, the private healthcare system should not financially benefit from the

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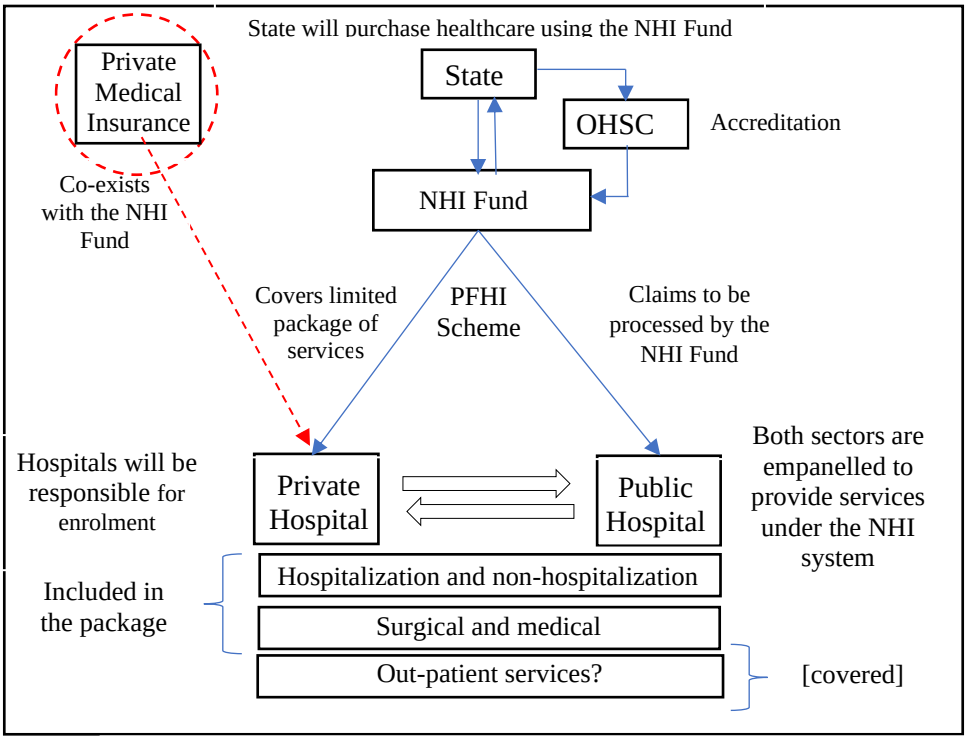
fatalities. Daily Covid-19 new infections recorded in the US were reaching over +50 000 cases every 24 hours. Also, in the US, over 10 million people had been infected and over 200 000 people had died from infection.

[6] No country that has tried the NHI system and its related programs has abandoned it. Those that have tried it partially usually expand it. Such has been the case in Canada. Canadians are attached and proud of their healthcare system. Canadians were supportive of the principles of the Canada Health Act and what they understand to be the core elements of the healthcare system, namely that the system is national and publicly-funded, and that it provides to Canadians universal health coverage (UHC) and *free healthcare* on the basis of need. Canada, like its US neighbour was battling the Covid-19 pandemic.

[7] Phadu and Thulare, 'For a working class-led NHI campaign.' The NHI Fund had been established by the passing of the NHI Bill. What was envisioned from the perspective of Covid-19 was that every citizen and non-citizen in South Africa would receive the NHI Card in order to access quality healthcare as soon as the NHI system was implemented and the NHI Act enacted. Focusing on building capacity in the public healthcare system in order to deal with the impact of the Covid-19 pandemic in South Africa became an imperative.

[8] Phadu and Thulare, 'For a working class-led NHI campaign.' As members of the ANC, Phadu and Thulare understand that Covid-19 has exacerbated the triple challenges of poverty, unemployment and inequality. Like them, I understood that Covid-19 posed not just a healthcare security threat but a national security problem. The Lockdown showed many in the ANC that the Covid-19 pandemic affected people's lives and livelihoods negatively. It has ushered in a new normal were health has become the central focus of every person. By the time cde Phadu and cde Thulare were presenting, wearing masks had become mandatory in the country and South Africa had not yet secured a vaccine for Covid-19. Even if it did, my point is that a Covid-19 vaccine, upon its availability, needed to be provided for free, to members of the South African population.

NHI Fund. The problem is that the NHI Fund in its design is understood within the framework of the contemporary firm. But, to meet its intended goals the proposed NHI system and the NHI Fund as its subsystem requires re-design. The diagram below shows the design elements of the NHI Fund:

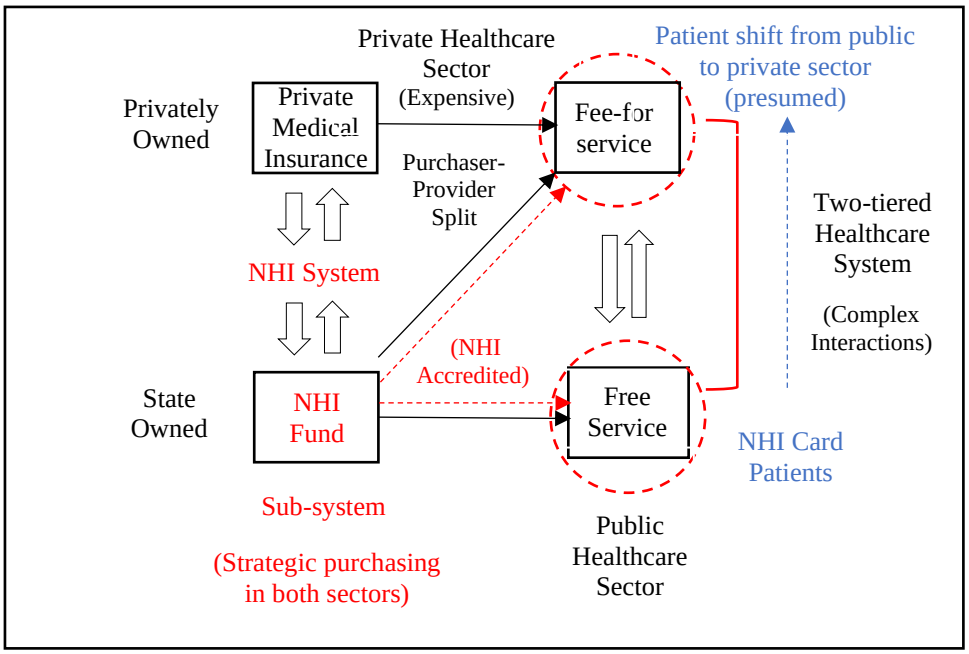


NHI Fund – a subsystem of the NHI system in South Africa

As the above diagram shows, the public and private healthcare systems are interconnected in a complex, adaptive system. The goal of the NHI system, is to improve health outcomes which are produced by healthcare systems (as well as socioeconomic factors). But the NHI system is expected to go beyond that. It must improve the conditions of the public healthcare sector, and this is a key point which is raised in the dynamics of the policy process. The reference point for the NHI Fund, according to the NHI Bill, is UHC and the way it has been incorporated into the South African context.[9] Every citizen and (eligible) non-citizens need to enroll with the NHI system. Gauteng province has started enrollment. Upon enrollment every person will receive an NHI Card (a biometric smart card). With such a card, patients (users) will be able to

[9] I contextualize this sentence building on, and incorporating, Nandi and Schneider's proposed framework. See Sulakshana Nandi and Helen Schneider, 'An equity-based framework for evaluating publicly-funded health insurance programmes as an instrument of UHC in India, with application to Chhattisgarh State,' Manuscript submitted for publication to Health Research Policy and Systems.

access any healthcare facility whether in the public or private healthcare sector. See diagram below:



NHI Fund as a strategic purchasing mechanism

In the above diagram, the target system (or system of interest) is the NHI Fund. The NHI Fund is a subsystem that interfaces with various elements within the NHI system. The private medical aid system is the first order system targeting the upper, and middle classes in society. The NHI card (an element of the NHI system) is the second order system targeting the entire population. I frame the NHI system as embedded within a complex adaptive healthcare system. Upon utilization of any healthcare facility by persons enrolled in the NHI system, the healthcare facility or healthcare practitioner (in the case of a doctor in private practice) will offer healthcare services for free at the point of care (at no cost to the user). The claims will be sent to the NHI Fund. Practitioners and healthcare facilities will be paid via capitation. Also, the NHI Fund will regulate tariffs (prices, fees, rates, billing, per case, per procedure rates, or per day rates). The NHI Fund is created to become a single risk pool. It acts as an intermediary and handles strategic purchasing. It behaves in the healthcare system as a gigantic healthcare insurance (state-owned) company.[10] It will process claims. Both public and private healthcare

[10] The Government Insurance System (GIS) in China was established in 1952. It was established before the Chinese transition to a market economy. At the time, China had a closed, centralized and planned economy. From the late 70's onwards, and well into the mid-80's, there was a systemic shift towards a market economy. This economic transition and shift had an observable effect in the healthcare economy. Such an effect was characterized by: *(i)* a decline in universal insurance

facilities (e.g. hospitals, clinics, etc.) shall be empaneled to provide healthcare services and products under the NHI Fund. However, the NHI Fund will cover a limited package of services, mostly provided by the private sector. Healthcare facilities in both the public and private sectors have to be accredited by the Office of Health Standards and Compliance (OHSC). The benefit package will include both hospitalization and non-hospitalization packages. The NHI Fund will also cover out-patient services.

In this framework (in the above diagram) there are non-linearities, multi-directionality, an interactive and iterative processes. Such processes guide the implementation of the NHI Fund. Also, with such processes, there will be positive and negative feedback loops along the pathway. Therefore, it is important to depict the design of the NHI system in South Africa, how it is going to be implemented and the impact of the NHI Fund as a Publicly-Funded Health Insurance (PFHI) scheme. My future interest will lie in seeking to understand the impact of the NHI Fund on health system building blocks. The elements of such building blocks are: (1) access (meaning people's access); access is linked (linkages) to three elements *(i)* affordability; *(ii)* availability; and *(iii)* acceptability. Phadu and Thulare suggest that, "The main NHI policy demands we have been advancing are founded on the core principles of: Universality ([where] everyone benefits from health system[s] not just the privileged)."[11] The challenge is that neoliberal governmentality has been unleashed in the post-apartheid democratic South Africa. Yet, it is destructive to the future of South African democracy.

If the NHI Bill establishes the NHI Fund, what shall be the impact of the NHI Fund if it does strategic purchasing in the private healthcare sector also? The private healthcare sector may expand.[12] The NHI Fund is planned to become a massive government intervention program,

coverage (UHC), *(ii)* an increase in out-of-pocket (OOP) payments, and *(iii)* the implementation of fee-for-service, especially when rural cooperatives were dissolved. The people in the rural areas lost their healthcare insurance. Thus, in the Chinese context, class structure is a much more complex social formation. The ruling-class replaced ownership and control of the means of production with control of the state apparatus as a more decisive criterion of social development.

[11] Phadu and Thulare, 'For a working class-led NHI campaign.' The Covid-19 pandemic context made the NHI system in South Africa an imperative.

[12] India has a mixed healthcare system with a large public healthcare sector. The public healthcare sector in India is underfunded. There is also a growing and unregulated private healthcare sector. Thus, India has committed to a national policy of Universal Health Coverage (UHC) for all. In this context, there has been two major strands of reform in the healthcare sector. The National Rural Health Mission [NRHM, renamed National Health Mission (NHM)] was launched in 2005. Its emphasis was on strengthening the public healthcare sector. Consequently, the second strand of healthcare reform was the Rashtriya Swasthya Bima Yojana (RSBY) launched in 2007. It targeted catastrophic healthcare expenditure by the poor in a variety of states. Relatedly, in India, class and race do not constitute autonomous and opposing phenomena. Hence,

specifically in the healthcare system. The NHI Fund will operate in a market economy. Its effects are yet to be seen. In its current context, healthcare is commercialized and has exchange-value.[13] Yet, healthcare must be viewed as a use-value, therefore, de-commercialized. Phadu and Thulare contesting the misconceptions that the "NHI is one big medical scheme" affirm that "it is not a medical scheme but fundamentally different in everything associated with a medical scheme. In fact, it is about creating a new healthcare system which will be free at the point of use."[14] In my view, challenging the dominant role of the exchange-value system in the provision of a use-value such as healthcare, for example, implies changes in the role of state money (NHI Fund) and modifying, if not abolishing, the private property rights regime in the healthcare system.[15] According to Phadu and Thulare, "The battle of ideas around National Health Insurance are too important to be left [to] "experts" and technocrats. We must make [the] NHI a people's campaign, with the working-class providing leadership."[16] Therefore, "with the working-class providing leadership" the NHI Fund should fund the public healthcare system *only* as an alternative to the two-tiered system approach which ensures that there is

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the goal of RSBY is to ensure that high quality and affordable healthcare services are accessible to the poor. However, the poor and the working-class are not subsumed under wider social and economic relations and treated as a superstructural phenomenon. In India, there is an added social dynamic, that of the caste system. In this context, the Indian government has implemented RSBY. However, in my view, RSBY is integral to the process of capital accumulation. Thus, RSBY has an ideological effect. It masks real economic relations. It provides insurance cover. At the time of writing, India was registering over 40 000 new Covid-19 infections daily. India had reached over 7.9 million Covid-19 cases.

[13] The Chinese ruling-class made an effort to privatize China's economy. The impact of such an effort led to the emergence of Chinese capitalists. Thus, within the context of the market economy (and the policy of privatization) the private healthcare sector expanded – healthcare was commodified. As a use-value that has value in exchange, healthcare was destined to be sold as a commodity in the market economy. As a result, private hospitals were built in China, especially in the urban areas and the cities. Consequently, pharmaceutical products became increasingly expensive, this led to the growth of the private healthcare sector. Thus, with the evolution of a capitalist (marketist) regime, the price of medicines increased. Healthcare became expensive and inaccessible for the poor and the working-class who could not afford healthcare services. Notably, there were inequalities of healthcare utilization by geographic area. The ideas of the ruling-class in China conveyed dominant material relationships, which became expressed as universal ideas. Chinese mainland, at the time of completion of the PhD dissertation, was registering 20 new Covid-19 cases and 1 locally transmitted case. Also, China was completing human trials of the Sinovac vaccine, and had authorized it for emergency use in various Asian countries such as, for example, Indonesia.

[14] Phadu and Thulare, 'For a working class-led NHI campaign.' Private medical aid schemes need to be done away with. Those that exist when the NHI Act is enacted need to be curtailed. Their combined resources need to be brought into the ownership of the South African state.

[15] David Harvey, *Seventeen contradictions and the end of capitalism* (London: Profile Books, 2015).

[16] Phadu and Thulare, 'For a working class-led NHI campaign.' Globally, and in South Africa particularly, Covid-19 was showing injustice of privatizing healthcare in the midst of a pandemic. The NHI needs to cease to become a campaign and it needs to become a reality, particularly in the context of the healthcare emergency that has affected everyone globally.

opposition between the private and public healthcare provision mechanisms in South Africa.[17] The NHI system must bring the entire healthcare system into the ownership and control of the state. Phadu and Thulare assert that,

> [Cosatu] and the SACP has been central to the demand for the state to play a greater role in providing quality healthcare for all and overcome our two-tiered healthcare system through [the] introduction of [the] NHI. The socialist axis of our broader movement has been demanding a universal and comprehensive quality healthcare for all, that is publicly funded and publicly administered and will be provided free at the point of service.[18]

Effectively, it is mainly Cosatu and the SACP jointly that are demanding the implementation of the NHI system, and that it be publicly funded and administered by the South African state. In this regard the "socialist axis of our broader movement" is demanding free healthcare for all in South Africa. Given the context that South African society remains dominated by the neoliberal paradigm of privatization, the challenge is that the post-1994 South African democratic state is construed on the model of the contemporary firm.[19] It is expected to comport itself in ways that: *a)* maximize capital value; *b)* enhance future value (capital enhancement); *c)* practice entrepreneurship and self-investment; and *d)* attract investors.[20] Hence, there remains a neoliberal governmentality in the restructuring of the current two-tiered healthcare system in South Africa. This neoliberal governmentality seeks to preserve the system – whereby private healthcare providers are contracted by the state (through the NHI Fund) to provide healthcare for all citizens free at the point of use/care. Neoliberal governmentality remains an injustice in relation to healthcare provision in South Africa as the country remains

[17] When comparing the German Statutory Health Insurance (SHI) system with the British National Health System (NHS), the concept of the NHS has been in existence in the United Kingdom (UK) since the 1940s. Historically in Britain, healthcare has been publicly provided and publicly financed. This means that there is access to *free*, quality, healthcare facilities for the entire British population (citizens and non-citizens). Unlike in Germany, such a system has existed independently of the private medical insurance industry. Yet, there remains a growing private healthcare sector, even though it exists within a country that has the NHS. Germany and the UK were battling the pandemic. During the second wave of the Covid-19 pandemic, the UK was recording over 500 fatalities in less than 24 hours and had surpassed 50 000 deaths.

[18] Phadu and Thulare, 'For a working class-led NHI campaign.'

[19] Brown, *Undoing the demos: neoliberalism, stealth revolution*, 22. In China, the private healthcare sector expanded, resulting in the rapid growth of infrastructure, medicines, medical products and medical devices concentrated in the urban areas. Poor households, especially in the rural areas, could not afford healthcare. The aim of Chinese capitalists within the private healthcare sector was to produce healthcare not only as a use-value, but as a commodity to be commercialized in the market economy for surplus-value creation. As a result, healthcare generally became unaffordable for the majority in the population.

[20] Brown, *Undoing the demos: neoliberalism, stealth revolution*, 22.

a racially divided and an unequal society. As I mentioned earlier, there are barriers to accessing healthcare due to inequalities of location in South Africa. In such a society, there are also racialized inequalities of wealth and power, indicative of persistent racialized spatial disparities. Phadu and Thulare suggest that,

> The organisational and technical resources of [Cosatu] and its affiliates [such as Nehawu] have been critical to ANC-led NHI policy development, over the past 15 years. We also need to [recognize] that commitment [to] some form of NHI has been a principal demand of our entire movement for many decades and were incorporated in the Freedom Charter.[21]

Though the origins of privatization of the healthcare system in South Africa and establishing a two-tiered system lie within, and has its foundations in, the racist apartheid system. Such a system of privatization ensured profit accumulation by the conglomerate private healthcare sector. The NHI system, however, has been the principal demand of the liberation movement for many decades. As Phadu and Thulare note above, free healthcare and hospitalization for all has been incorporated in the Freedom Charter. Thus, a racialized co-existence – in a racialized capitalist phase in South African democracy – has resulted in the two-tiered system, and approach whereby in the transition to democracy privatisation of healthcare by healthcare conglomerates emerged.[22] The resulting percentage distribution of the healthcare budget to the private (4.4%) and public (4.1%) healthcare sectors remains. There are ideological and political philosophical inconsistencies with this two-tiered approach. Such inconsistencies are also due to the fact that the two-tiered healthcare system is currently divided along racial and class lines.[23] In principle, Phadu and Thulare reject the two-tiered system and advocate for the de-commodification of healthcare. They maintain that,

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[21] Phadu and Thulare, 'For a working class-led NHI campaign.' I have once mentioned in both a Nehawu meeting and a Cosatu meeting in Gauteng that the NHI system needs to be given philosophical attention. It is my hope that this dissertation contributes to the philosophical attention that the NHI policy and legislation demands, and that it will give ideological guidance to both the SACP and Cosatu regarding the implementation of the NHI system.

[22] It is not the case that the introduction of a two-tiered healthcare system in South Africa was a move in the direction the world was going at the time, the move was inspired by a racialized healthcare system in South Africa during the time of apartheid.

[23] Class antagonism became only one aspect or factor in explaining any dynamic in the Cuban social situation. The concept of class in Cuba galvanized into a relation of group antagonism (more precisely, class conflict) – the distinctive characteristic of the social totality of capitalism. Class signified an element of identity – a phenomenon whose meaning and value became incomplete without considering other factors such as race, gender, locality, and income. The activity of healthcare production and healthcare related labour came to be understood in terms of specialized labour of the medically skilled

> It is a principle therefore that rejects the two-tiered health system – [the] two-tiered system provides different types of health coverage benefits for different sections of the population. The universality principle also implies that healthcare must be de-commodified – it cannot be left to the forces of the market.[24]

Phadu and Thulare above, also echo my point that: the healthcare system "cannot be left to the forces of the market." Therefore, privatisation of healthcare in South Africa needs to be negated.[25] Also, the financing of private healthcare using the NHI Fund also needs to be negated.[26] To eliminate the private healthcare sector will add value to the NHI system and will further strengthen the public healthcare sector in the country.[27] The state must achieve a single-tier quality healthcare delivery option and ensure that it is under state control. With this option healthcare must be de-commodified and de-commercialized. This perspective poses a Marxist-socialist set of political philosophical principles which I have presented as a preferable basis for the provision of UHC in South Africa.[28] Phadu and Thulare affirm that,

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workers, and the creative aspects of healthcare production were not overlooked, neither was a historically specific, productivist notion of healthcare production *accepted* as a trans-historical given.

[24] Phadu and Thulare, 'For a working class-led NHI campaign.'

[25] No private healthcare system in reality can remain 'in-itself,' that is isolated, detached, or protected (from becoming negated). Negation is a refusal of existence. The "nationalization of private hospitals," and "nationalization of pharmaceutical companies" became real in Cuba. But where am I to place negation? Cuba negated privatization in the healthcare system. The intrinsic *uncertainty* of the public healthcare system appeared like it was a weakness, but it actually turned out to be a strength, the nationalization of the entire healthcare system (and the negation of the private healthcare sector) assisted the Cuban system to have sufficient reserves to constantly try out new things so as to be prepared for any eventuality.

[26] The Cubans refused that the conglomerate private healthcare sector continue to exist in the Cuban national healthcare system. Having gathered together all the means of healthcare production and healthcare practitioners (labour power) the Cubans reorganized and supervised the healthcare production process in its entirety. The resulting outcome was that healthcare was decommercialized – meaning: not sold. For negation is a category that nihilates a being, cause it to be thrown back into non-being. The Cubans removed the slightest negativity from the negation of the private healthcare sector. They nihilated it. Healthcare was decommodified. They put into praxis the idea that dialectical unity is not a confusion of the contradictory terms as such, but a unity which passes through the contradiction and is re-established at a higher level. The Cubans created a *unified* NHS in a single-tier healthcare system.

[27] Phadu and Thulare, 'For a working class-led NHI campaign.'

[28] Brazil has a hybrid policy regime. Like China, it has adopted both neoliberal and state-interventionist policies. However, social conditions in Brazil today are characterized by a dialectical inversion with regards to healthcare. Quality healthcare in Brazil is a right. Though today it appears that quality healthcare is a right that financially benefits only those in possession of the means of healthcare production (to appropriate the surplus-value). Brazil established the largest public healthcare system referred to as *Sistema Único de Saúde (SUS)*. Significantly, it is a system of free and Universal Health Coverage (UHC). However, in Brazil, there are deep concerns with overcoming the potentially divisive impact of racism on class organisation and radical political action.

> The present two-tiered health system is organised, funded and delivered in such a way that those with less need for healthcare (rich) [have more healthcare resources: finance and human services than those with the greatest need (the poor)]. The consequence has been a public health sector experiencing a significant [*sic*] shift [in] health resources (funding and human resources) towards for-profit private health sector which treats healthcare as a commodity – [*i.e.*] to be bought and sold for a minority of the population who can afford [it]. However, it is a reality also exacerbated by years of neo-liberal fiscal austerity on healthcare – (budgets cuts, outsourcing, closure of nursing colleges etc.).[29]

Phadu and Thulare, in the above quotation support my position, that the private healthcare system treats healthcare as a commodity to be bought and sold for a minority of the South African population who can afford it. This is a reality also exacerbated by years of neoliberal fiscal austerity. Should the private healthcare sector insist on participating in the NHI system, or should the government want to engage the private healthcare sector using the NHI Fund, instead of using public funds to purchase healthcare from the private healthcare sector, the government should bring the private healthcare sector under the public healthcare system and transfer ownership of the sector. Thus, eliminating private ownership of conglomerate healthcare facilities.

The proposed one-system approach to the NHI may offer an advantage.[30] The conglomerate private ownership of the means of healthcare production is embedded within an exploitative system where labourers are commodified, were healthcare workers are regularly hired and exploited. The two-tiered system of healthcare provision only financially benefits the owners of healthcare production (healthcare conglomerates). In such a system, healthcare workers (such as nurses and doctors, for example), who use and work in the private healthcare sector remain exploited. The status quo of the two-tiered healthcare system needs to be abolished. UHC, envisaged by the NHI system, cannot be realized by accommodating the current two-tiered system and approach to healthcare delivery that the South African government has adopted. Phadu and Thulare note that, "International experience shows, that where there is single or common health fund administered by the state on behalf of the entire population, the advantages and benefits in pooling funds, purchasing services and contracting with providers

[29] Phadu and Thulare, 'For a working class-led NHI campaign.'

[30] Phadu and Thulare, 'For a working class-led NHI campaign.'

are far greater for the country."[31] Therefore, political attention and philosophical intervention in the policy and legislative processes in both the ANC and government is necessary. Otherwise, the NHI system may set the foundations for expanding the current two-tiered healthcare system. If such a system is adopted the private healthcare system will negatively impact the goal and ideals of the NHI system, thereby perpetuating an injustice in the country. There is a necessity to guide the implementation of the NHI system. In a state-owned system, the tendering system within the healthcare sector needs to be discarded. The alternative is to unify healthcare under public provision and state ownership.

[31] In China, insurance reforms were implemented to improve access and utilization of the private healthcare sector. Such reforms were aimed at reducing costs, and also at providing higher risk protection, particularly for rural populations. The basis of such healthcare insurance reforms was redress, particularly the redress of healthcare inequalities between rural and urban areas. Pilot programs were initiated in certain areas with the strategic intention of up-scaling nationwide. Public healthcare reforms were driven concurrently with private healthcare sector expansion within the context of a market economy. During this period, there was a marked increase in the number of general and specialist hospitals. The Chinese ruling-class then decided to recreate the Rural Cooperative Medical Scheme (RCMS) which was based on earlier communist models and it also formed the Medical Financial Assistance program (MFA) to assist the poor with their medical expenses. Additionally, the Chinese ruling-class conducted a strategic state intervention program of massive investment in the building of healthcare facilities in the rural areas, and here they succeeded.

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