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THE IMPACT AND CONSTITUTIONALITY OF THE PROPOSED NATIONAL HEALTH INSURANCE SCHEME WITH REGARD TO THE PROVISION OF HEALTH SERVICES BY SUBNATIONAL GOVERNMENTS

DECLARATION

I, Candice James, declare that '**The Impact and Constitutionality of the Proposed National Health Insurance Scheme with regard to the Provision of Health Services by Subnational Governments**' is my own and has not been submitted before for any degree or examination at a University. I declare that all the sources I have used or quoted in this paper are acknowledged as complete references.

Student: Candice James

Signature: C. James

DEDICATION

I dedicate this thesis to the little girl who always felt that she had something to prove to everyone, until she realised she only needed to prove something to herself.

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KEYWORDS

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Conditional grant

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Exclusive powers

Health services

Municipal health services

National Health Insurance

National Health Insurance Fund

National Health Laboratory Services

Primary Health Care

Provincial equitable share

Referral system

Stewardship

Universal health coverage

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CHAPTER 1: INTRODUCTION

1.1. Problem statement

In South Africa, there are two health systems through which health services are delivered,[1] namely private and public. These two systems were inherited from the apartheid regime.[2] With South Africa's political change from a system of parliamentary sovereignty to a constitutionally supreme system in 1996, huge changes were bound to come including changes to the health sector.[3] This meant the overhauling of health legislation, as the right of access to health care services became guaranteed in the Constitution of the Republic of South Africa, 1996.[4] In 1997, the *White Paper on the Transformation of the Health System* (*White Paper on Health*)[5] was introduced with the aim of developing a national health system.[6] There has been a lot of progress made in reforming the health sector, however there are still many cracks that the national government aims to remedy through the realisation of universal health coverage (UHC).

There are vast inequalities in the health sector, which can be attributed to the existence of two health systems.[7] There is an unequal distribution of health professionals between the two systems.[8] The public health system is used by approximately 80 per cent of the population while the private system is used by the remaining 20 per cent of the population, who have medical aid and/or make

[1] Section 1 National Health Act 61 of 2003 defines health services to mean a) health care services including reproductive health care and emergency treatment, b) basic nutrition and basic health care services, c) medical treatment and d) municipal health services.
[2] Botha C & Hendricks M *Financing South Africa's National Health System through National Health Insurance: Possibilities and Challenges* (2008) 1.
[3] De Vos P & Freedman W (eds) et al *South African Constitutional Law in Context* (2014) 36.
[4] Blum J, Carstens P & Talib N 'Government public health policy: Three cautionary tales from Malaysia, South Africa and the United States' (2007) 26 (4) *Medicine and Law Journal* 625-6.
[5] *White Paper on Health* (published in *GG* 17910 of 1 July 1997).
[6] Botha & Hendricks (2008) 1.
[7] Kautzky K & Tollman SM 'A perspective on primary health care in South Africa' in Barron P & Roma-Reardon J (eds) *South African Health Review* (2008) 24.
[8] According to the Health Professions Council of South Africa (HPCSA) less than a third (10 653 out of 34 687) of medical professionals registered with the HPCSA work in the public sector. See Lloyd B *Stakeholder Perceptions of Human Resource Requirements for Health Services Based on Primary Health Care and Implemented Through a National Health Insurance Scheme* (unpublished LLM thesis, University of the Western Cape, 2011) 11.

out-of-pocket (OOP) payments.[9] The cost of health care from private health facilities makes them inaccessible for most of the population.[10] This exacerbates the unequal access to quality health services and causes unequal standards of care between the two systems.

Regarding the public health system, the Constitution provides that the regulation and provision of public health services in South Africa fall within the domain of all three spheres of government namely national, provincial and local.[11] National and provincial governments have concurrent powers regarding health services while local government has the competence regarding 'municipal health services'.[12]

In practice, the responsibility of each sphere regarding health services differs. The National Department of Health (NDoH) is primarily concerned with policymaking on health issues, and establishing norms and standards.[13] The NDoH is rarely involved in the actual delivery of health services.[14] Provinces are mainly concerned with the actual delivery of health services. Provinces deliver a range of personal health services from primary health care (PHC) to specialised care through most public clinics and all public hospitals (from district through to central)[15] that are owned by provincial governments.[16] Moreover, provincial governments are also responsible for the provision of emergency medical services (EMS) in their respective provinces.[17] EMS include ambulatory services. Ambulance services are an exclusive competence of provincial

[9] Financial and Fiscal Commission *Submission for the 2015/16 Division of Revenue: Adequacy and Efficiency in Primary Health Care* (2014) 69.
[10] Conmy A 'South African health care system analysis' available at *https://pubs.lib.umn.edu/index.php/phr/article/download/1568/1349/* (accessed 26 June 2019).
[11] Schedule 4 Constitution.
[12] Schedule 4 Constitution.
[13] Section 21 Act 61 of 2003.
[14] Serfontein J 'State takeover of academic hospitals is not the answer' *BusinessDay* 12 July 2019 9.
[15] Section 1 Act 61 of 2003 defines central hospitals as public hospitals that are designated by the Minister of Health to provide health services inter-provincially. Provinces own all public hospitals and as such provinces own central hospitals too, despite the name of these hospitals denoting national in other contexts.
[16] Shivani R, Adams C, Burger R et al 'South Africa's hospital sector: Old divisions and new developments' in Padarath A & Barron P (eds) *South African Health Review* 20 ed (2017) 102.
[17] Section 25(2)(*m*) Act 61 of 2003.

governments.[18] Currently, at local government level, PHC and secondary health services are provided through the district health system (DHS) that is made up of clinics, community health centres and district hospitals. The managers of district hospitals lack operational decision-making as these hospitals are administered by provinces.[19] Metropolitan municipalities also deliver PHC services while local municipalities and district municipalities provide municipal environmental health services.[20] In addition, local government has a limited role in delivering emergency medical health services.[21]

The public health sector faces many challenges at all three levels of government. The NDoH is known to have been lacking stewardship of the public health sector.[22] At the provincial government level, the differences in health expenditure across provinces lead to varying health outcomes.[23] Bidzha asserts that provinces reprioritise funds away from health and this reprioritisation results in poor health delivery in public hospitals.[24] In addition, the lack of financial resources can be attributed to the public sector serving a larger portion of the population.[25] This results in the public health sector being under-resourced. Moreover, the lack of (or sub-standard) equipment places EMS providers in a position where they offer little assistance in emergency situations which

[18] Schedule 5A Constitution.
[19] Rispel LC 'Analysing the progress and fault lines of health sector transformation in South Africa' in Padarath A, King J & Mackie E et al (eds) *South African Health Review* (2016) 19.
[20] May A 'Environmental health and municipal public health services' in du Plessis A (ed) *Environmental Law and Local Government in South Africa* (2015) 510. Section 1 National Health Act 61 of 2003 defines municipal health services as services including: 'water quality monitoring; food control; waste management; health surveillance of premises; surveillance and prevention of communicable diseases, excluding immunisations; vector control; environmental pollution control; disposal of the dead; and chemical safety; but excludes port health, malaria control and control of hazardous substances.'
[21] Bidzha ML *The Effectiveness of Public Health Spending in South Africa* (unpublished Master of Commerce thesis, University of Johannesburg, 2015) 11.
[22] Stewardship refers to leadership and governance. Whitford FJ *Health Service Delivery in the Western Cape: A Measurement of Perceptions* (unpublished Masters in Public Administration thesis, Stellenbosch University, 2016) 18.
[23] Bidzha (2015) 22.
[24] Bidzha (2015) 13.
[25] Rispel L 'South Africa's universal health care plan falls short of fixing an ailing system' *City Press* 29 June 2018 available at *https://city-press.news24.com/Voices/south-africas-universal-health-care-plan-falls-short-of-fixing-an-ailing-system-20180629* (accessed 12 July 2019).

exacerbates the poor quality of health service delivery.[26] With an under-resourced public health sector, staff become overworked. An under-resourced and understaffed public health sector results in low staff morale and decreases the quality of health services and thus a lack of patient satisfaction.[27] Moreover, the referral system, in practice, is weak.[28] Users do not adhere to referral pathways and health professionals do not stringently enforce referral pathways.[29] Similarly, at local government level, there is a lack of human resources and lack of managerial capacity.[30]

Currently, South Africa has no national health insurance (NHI). The national government proposes an NHI scheme to bring the two health systems (public and private) under one authority. Addressing the inequalities of the public health system is among the factors that have propelled the introduction of the White Paper on the NHI.[31] The NHI is aimed at improving access to quality health services by redistributing resources and ensuring that vulnerable groups (such as women and children, elderly, the poor and people with disabilities) are prioritised.[32] On numerous occasions, President Ramaphosa expressed his full support of the NHI, asserting that the NHI is aimed at eliminating the inequality present in the current health system and to make universal access to health care for all a reality.[33] The NHI will be a public financing system which seeks to

[26] Van Huyssteen N *A Legal Analysis of the Emergency Medical Services in South Africa* (unpublished LLM thesis, University of Pretoria, 2016) 65.
[27] Citizen Reporter 'The NHI health plan raises some serious concerns' (The NHI health plan) *The Citizen* 13 August 2019 available at *https://citizen.co.za/news/opinion/opinion-editorials/2165893/the-nhi-health-plan-raises-some-serious-concerns/* (accessed 13 August 2019).
[28] The referral system is a system where health users are expected to access the most basic level of care (that is PHC) before receiving more intense clinical and specialist care, as a user goes up the hierarchy of different levels of care. Citizen Reporter 'Zweli Mkhize announces NHI bill: How you will be affected (and goodbye medical aid)' (Zweli Mkhize announces NHI bill) *The Citizen* 12 August 2019 available at *https://citizen.co.za/news/south-africa/health/2164964/watch-zweli-mkhize-announces-nhi-bill-how-you-will-be-affected-and-goodbye-medical-aid/* (accessed 13 August 2019).
[29] Von Holdt K & Murphy M 'Public hospitals in South Africa: Stressed institutions, disempowered management' in Buhlungu S, Daniel J, Southall R (eds) et al *State of the Nation: South Africa 2007* (2007) 313.
[30] Coovadia H, Jewkes R, Barron P et al 'The health and health system in South Africa: Historical roots of current public health problems' (2009) 374 (9692) *The Lancet Journal* 817.
[31] Oosthuizen WT *An Analysis of Healthcare and the Malpractice Liability Reform: Aligning Proposals to Improve Quality of Care and Patient Safety* (unpublished LLM thesis, University of Pretoria, 2014) 115.
[32] Oosthuizen (2014) 115.
[33] Staff Reporter 'NHI is about social justice…it must work- Ramaphosa' (NHI is about social justice) *City Press* 24 August 2018 available at *https://city-press.news24.com/News/nhi-is-about-social-justice-it-must-work-ramaphosa-20180824* (accessed 12 July 2019).

make health services more affordable for both private and public system users by collecting funds from private and public revenue.[34] An NHI Fund (Fund) will be established where these funds will be consolidated. The Fund will purchase health services on behalf of the population so that health care users access services for free at the point of care.[35]

On the one hand, the NHI has been heavily criticised in the media and other platforms. Some critics lament that the NHI is unaffordable and is aimed at marginalising the private health sector.[36] On the other hand, supporters contend that the NHI is needed to equalise the fragmented health sector.[37] The NHI is proposed to overhaul the current health system by making several changes to both the private and public health sector.

The NHI will make several reforms to the public health sector. Four of these reforms will be highlighted below (additional reforms will be explored in chapter three). First, the NHI proposes the nationalisation of central hospitals. Some provinces that are led by the African National Congress (ANC) seem to be on board with this proposal.[38] The NHI aims to eliminate user fees charged at hospitals as these fees deter groups (the so-called missing middle) that fall within the income bracket where they are presumed to be able to afford public hospital care.[39] The NHI does,

[34] Medical scheme tax credits (which is a rebate that reduces the normal tax paid by a person to a registered medical scheme) which are usually paid to medical schemes will be reallocated to the Fund. The Fund will also receive public revenue through surcharges on personal income tax and general taxes. Khumalo K 'Higher taxes on the cards as government scrambles to implement NHI' *IOL* 12 August 2019 available at *https://www.iol.co.za/business-report/economy/higher-taxes-on-the-cards-as-government-scrambles-to-implement-nhi-30673151* (accessed 12 August 2019).

[35] Rispel (2018) 1.

[36] Urbach J 'SA's wasted NHI millions could have been spent better' *City Press* 28 March 2019 available at *https://city-press.news24.com/Voices/sas-wasted-nhi-millions-could-have-been-spent-so-much-better-20190328* (accessed 12 July 2019).

[37] African News Agency '#NHIBILL: Proposed new health laws will help the poor, says Sanco' *IOL* 22 June 2018 available at *https://www.iol.co.za/news/politics/nhibill-proposed-new-health-laws-will-help-the-poor-says-sanco-15629978* (accessed 12 July 2019).

[38] Legal Brief 'Hospital transfers in line with NHI Bill' *Legal Brief* 4 July 2019 available at *https://legalbrief.co.za/search.?q=Nhi* (accessed 19 July 2019).

[39] The so-called missing middle category are a category of people who pass the 'means test' that evaluates whether a person is employed and falls within the income bracket which requires them to pay for the health care provided at a public hospital. Pearmain DL *A Critical Analysis of the Law on Health Service Delivery in South Africa* (unpublished LLD, University of Pretoria, 2004) 470.

however, provide that user fees might have a potential application where NHI-covered users do not adhere to the strict referral based system that will be put in place.[40]

Secondly, the NHI will play a role in the operation of EMS.[41] The NHI Fund will contract with EMS in both the private and public health sectors. The NHI will equalise the level of quality provided by EMS. How the NHI will do this remains unclear.[42]

Thirdly, the NDoH will nationalise the procurement of laboratory services.[43] Currently, provinces procure laboratory services. Under the NHI, a defined package of laboratory services will be offered to public clinics and hospitals. The national government opines that it (i.e. national government) is the sphere best equipped to handle the procurement of laboratory services as provincial governments overspend on blood testing and other laboratory services.[44]

Fourthly, according to the NDoH, the NHI Fund can rely on the portion of government funding usually transferred to provinces to deliver health services.[45] This means that there will be a substantial reduction in the provincial equitable share (PES), as health funding is a huge portion of the PES. This reduction in the PES is likely to have ripple effects on provinces' powers in relation to health service provision, as revenue is needed to perform these functions.[46]

Moreover, the NHI Bill proposes several deletions and substitutions to the National Health Act (NHA) amongst other legislation, largely directed at provincial government functions.

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[40] *White Paper on the NHI* (2017) 52.
[41] EMS has developed to become a system that provides acute pre-hospital care and transporting patients with illnesses that make it impossible for the patients to transport themselves to hospitals. Van Huyssteen (2016) 7-17.
[42] *White Paper on the NHI* (2017) 32.
[43] The National Health Laboratory Services (NHLS) where provinces procure laboratory services used to be an independent public entity which the state had no direct control over, until the state shifted the NHLS to the NDoH in 2015. Financial and Fiscal Commission (FFC) *Submission for the Division of Revenue 2019/2020 Recentralisation: Implications for Service Delivery and Intergovernmental Fiscal Relations in South Africa* (2018) 48.
[44] Ministry of Finance *The Division of Revenue Bill* (*DOR Bill*) (published in *GG* 40610 of 10 February 2017) (2017) 106.
[45] Department of Health (NDoH) 'NHI booklet' available at *https://www.health.gov.za/index.php/nhi/category/274-nhi-booklets* (accessed 26 June 2019).
[46] FFC *NHI Colloquium Overview of the NHI and its Implications on the Intergovernmental System and the Current Fiscal Arrangements* (2016) 7.

1.2. Research question

Will the creation of a National Health Insurance (NHI) scheme reduce the role of subnational governments in providing health services? If so, will it pass constitutional muster?

The above questions will be informed by the following sub-questions:

1. How are health services currently provided for in the Constitution, legislation and in practice and how is public health funded?

2. How will the NHI work and will it impinge on subnational government functions regarding health services?

3. If so, are the imposition(s) constitutionally permissible?

4. If constitutionally permissible, what are the policy implications, if any, for the status and role of provinces and local government in general?

In answering the questions above, the positions of provinces and municipalities will be considered separately.

1.3. Argument

The Constitution and legislation (in particular) give provinces significant powers regarding public health services. In practice, provinces are the main role players in the actual delivery of public health services, compared to the other two spheres. The Constitution and legislation provide local government with a smaller role in public health services. Metropolitan municipalities deliver PHC services while local and district municipalities are limited to delivering environmental health services.

In discharging their function as the main provider of public health services, provinces receive funding through transfers from the national fiscus, in the form of PES and conditional grants due to provinces' limited tax base. Expenditure on health services account for over a third of provinces'

expenditure.[47] Local government receives funding through an equitable share and conditional grants. As municipalities have a substantial tax base, they use their own revenue to deliver municipal health services.

The NHI will be a public financing system that will purchase and pay for health services from private and public health service providers. Under an NHI scheme the procurement of laboratory services will be nationalised and this would be an imposition on provinces' administrative autonomy to procure their own laboratory services. In addition, the proposed contracting of public EMS and paying these EMS providers on a capped case-based fee basis is an imposition as provinces are responsible for EMS. Moreover, the nationalisation of central hospitals will impede on provinces' administrative autonomy to run their own hospitals.

On the face of it, these abovementioned impositions appear to be constitutional. Health services are a concurrent function, which enables the national government to introduce a scheme such as the NHI. It can be argued that the lack of definitional clarity of health services as provided in the Constitution make these impositions constitutionally permissible.[48] There are however, certain aspects of the NHI where the constitutionality becomes questionable, on deeper inspection. These aspects relate to the nationalisation of central hospitals and procurement of laboratory services, to name a few.

Provinces' role in the multilevel government system has been undermined and is deteriorating. The nationalisation of the administration of social grants (which was previously fulfilled by provinces) is one such example.[49] Currently, the introduction of the NHI Bill and its content appear to reduce provinces' role regarding health services. Provinces will only be left with the education

[47] Approximately 30 to 35 percent of provinces total budget is allocated to health. FFC *Submission for the Division of Revenue 2019/20: Provincial Fiscal Adjustment Mechanisms in Times of Protracted Fiscal Constraints – Case of the Health Sector* (2018) 62.
[48] Pearmain (2004) 341.
[49] FFC (2018) 34.

function if they lose the health function. The national and local government spheres could be benefiting at provinces' expense. This is argued because the health portion of the PES and health-related conditional grants will be transferred to the national government and the delivery of PHC services to local government with the district health management offices (DHMO) managing, facilitating and co-ordinating the provision of PHC services. The DHMO will, however, be established as a component of the national government, under a NHI scheme that would expand national government's role in relation to health services in practice.

Therefore, the issue is whether the reduction of subnational government's current role in health services is constitutional. On a preliminary inspection, the NHI and the imposed reductions could pass constitutional muster as health services is a concurrent function and the national government could expand its own powers in relation to health services. A more detailed look at the NHI, however, might prove otherwise.

1.4. Literature survey

First, there is vast literature on the provision of health services in South Africa of both the private and public health systems. Pearmain contrasts public health provision with private health provision and submits that the public sector is not as competitive as the profit-driven private sector. She contends that this is due to the constitutional obligation (amongst other drivers) placed on the state to provide access to health services especially for vulnerable people.[50] Shivani *et al* take a narrower focus of public health services by focusing on public hospitals. Shivani et al note that provinces own all public hospitals and most clinics through which public health services are delivered and that these hospitals and clinics are directly accountable to their relative provinces.[51] In addition,

[50] Pearmain (2004) 494.
[51] Shivani, Adams & Burger (2017) 102.

Pearmain notes that in owning public hospitals, provinces also employ their own health professionals.[52]

Van Huyssteen, on the other hand, draws attention to the legal aspects of EMS, which she asserts is not as academically rich as other aspects of health services.[53] She submits that EMS falls within the medical profession and is subject to certain laws, rules and regulations.[54] Van Huyssteen's work however is mainly focused on private EMS and how this relates to private law as opposed to public law. Although these academics write about the public health system, their work does not delve into provinces' role in relation to health service delivery in the public health system, which will be done in this paper.

Secondly, there is an array of literature on the problems in the public health sector. Chopra highlights a paradox present in the public health sector as high health expenditure and supportive policies but continued poor health outcomes.[55] Mayosi et al submit that access to health care in South Africa has deteriorated.[56] The inequalities in the public health sector have also been extensively written about, with academics such as Bidzha contending that the inequalities present can be attributed to provinces' failure to prioritise funds toward providing health services. Instead, provinces prioritise funds away from health services.[57] Bidzha further asserts that this reprioritisation plays a major role in the decrease of quality regarding public health services. In addition, McIntyre highlights that the historical budgeting practices of provinces and equitable share allocations to provinces are the main contributors for these inequalities.[58]

[52] Pearmain (2004) 32.
[53] Van Huyssteen (2017) 6.
[54] These laws include the Constitution and Act 61 of 2003 to name a few. Van Huyssteen (2017) 26.
[55] Chopra, Lawn & Sanders (2009) 1025.
[56] Mayosi BM, Lawn JE, Van Niekerk A et al 'Health in South Africa: Changes and challenges since 2009' (2012) 380 (9858) *The Lancet Journal* 2036.
[57] Bidzha (2015) 13.
[58] McIntyre & Ataguba (2018) 13-14.

Thirdly, since the NHI was mentioned there has been some writing on it relating to affordability, practicality and to some extent the constitutionality. Amado argues that past attempts to bring about equitable resource allocation have not necessarily been successful and that the NHI could possibly follow in these footsteps.[59] Van Huyssteen also submits that the current basic structures in the public health sector should be improved, otherwise the implementation of the proposed NHI will be impossible.[60] Coovadia recommends that good leadership and stewardship must be in place and better management of health services are of paramount importance if South Africa aims to achieve UHC.[61] Recommendations of good leadership and stewardship are important, however, respecting the integrity of other spheres while enhancing leadership and better management in public hospitals and clinics will be explored in this paper.

Moreover, the Financial and Fiscal Commission (FFC) suggests that any residual powers regarding health service provision should be made clear under the NHI.[62] McIntyre argues that the proposed NHI is constitutionally permissible, because the NHI will play a major role in addressing the inequalities that exist because of the fiscal federal system.[63] With the introduction of a Green Paper and the White Paper on the NHI, academic literature increased.[64] Oosthuizen submits that policies such as the NHI require extensive scrutinisation, as major overhauls of the health system may not necessarily benefit citizens or the population.[65] Importantly, Oosthuizen asserts that shifting priorities from hospitals to PHC services, should not be done in a manner that de-prioritises hospital services.[66] Subsequent to Oosthuizen's research, the White Paper on the NHI and an NHI Bill were released. The content of his work however is useful as a building block for this thesis.

[59] Amado L, Christofieds N, Pieters R et al 'National health insurance: A lofty ideal in need of cautious, planned implementation' (2012) 5 (1) *South African Journal of Bioethics and Law* 5.
[60] Van Huyssteen (2016) 117.
[61] Coovadia, Jewkes & Barron (2009) 817.
[62] FFC (2016) 2.
[63] McIntyre & Ataguba (2018) 29.
[64] Policy on National Health Insurance (Green Paper on the NHI) (GN 657 in *GG* 34523 of 12 August 2011).
[65] Oosthuizen (2014) 2.
[66] Oosthuizen (2014) 133.

Fourthly, there has been some legal literature on the right of access to health services. De Vos and Freedman highlight that socio-economic rights are rights to things such as health care services.[67] This places a positive obligation on the state and therefore requires the state to plan and expend resources so that people can access those health resources, as submitted by De Vos and Freedman.[68] The state however should do this within its available resources.[69] Similarly, Pearmain submits that even the Constitution recognises that the state's ability to realise the right of access to health care services is limited by the resources the state has available.[70] Pearmain examines the provision of health services and submits that the provision of public health services is not only dependent on the right of access to health care but other rights in the Bill of Rights.[71]

Fifth, much has been written on the constitutional position of provinces, their role and their future. De Visser and May highlight that concurrent areas such as health services see provinces delivering health services by implementing national policies and rarely taking up their legislative powers to enact laws in areas of concurrency.[72] They also note that there has not been a single case that has appeared before the courts about the concurrent powers.[73] In addition, they submit that provinces have been reluctant in pushing the envelope with their powers as it is generally met with hostility by courts.[74] De Vos and Freedman submit that while having regard for provinces' ability to provide basic services, section 214(2) of the Constitution is structured in a manner that requires the division of revenue needed to fulfil functions to be looked at through the 'prism of national objectives'.[75] In addition, Pearmain submits that any disruptions in the distribution of health care resources and policies that relate to the delivery of health services, can result in serious financial and other

[67] De Vos & Freedman (2014) 667.
[68] De Vos & Freedman (2014) 667.
[69] Section 27(2) Constitution.
[70] Pearmain (2004) 528.
[71] Rights such as the right to dignity, right to life to name a few. Pearmain (2004) 131.
[72] De Visser & May (2015) 171.
[73] De Visser & May (2015) 169.
[74] De Visser & May (2015) 171.
[75] De Vos & Freedman (2014) 307.

difficulties for provinces.[76] She asserts that the interface between the national government and the provincial governments regarding health service delivery is dependent on there being a delicate balance between the distribution of resources and policies relating to the delivery of health services.[77] Pearmain does not necessarily explore the impact of an NHI on provinces' ability to deliver health services as the possibility of an NHI scheme was only an ideal at the time. This paper intends to add to Pearmain's submission by looking at the serious financial implications of reducing the PES and the difficulties provinces will have under the NHI in delivering health services.

Moreover, Steytler addresses the important role provinces play in policy innovation. He argues that although this idea of creating uniformity is usually based on the centre being right, there are however instances in which the centre can be wrong, and uniformity can be achieved from the periphery to the centre.[78] Steytler's arguments are, however, limited to the National Human Immunodeficiency Virus (HIV) and Acquired Immunodeficiency Syndrome (AIDS) (HIV/AIDS) Policy to illustrate provincial innovation, but it is nonetheless important to show how this innovative role of provinces could be diminished through a predetermined package of health services under an NHI scheme.

There is limited literature on provinces' role in relation to health services. De Visser and May delve into provincial functions regarding health services, however, their research is limited to a general overview of the functions and powers of provinces. In addition, May examines the role of local government in health service delivery and notes that there will be implications of re-engineering the PHC services through the proposed roll-out of health interventions through the district based clinical support teams which will be supporting the delivery of PHC services.[79] May,

[76] Pearmain (2004) 34.
[77] Pearmain (2004) 34.
[78] Steytler (2003) 59.
[79] May (2015) 494.

however, does not address the possible impact that the NHI will have on the autonomy of provincial governments which currently deliver these PHC services (aside from metropolitan municipalities). These academics do not provide an extensive focus on health services as a concurrent functional area. This thesis is aimed at providing a focus on health services as a concurrent functional area.

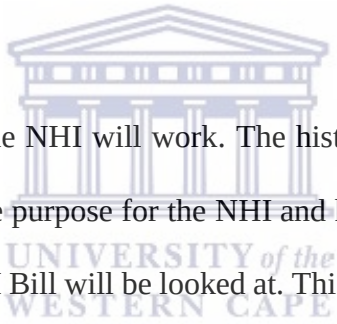
Currently, there has been no literature on the impact of the NHI on provincial autonomy. The FFC does highlight that the funding under an NHI scheme will shift, but not necessarily the functions. It further highlights that provinces could still be responsible for health services provision without controlling the budget.[80] The FFC also notes that concurrency may be complicated as health care providers will have to account to the NHI Fund (Fund), not provinces.[81] The FFC however has not adequately addressed the impact of a reduction of powers of provinces, which this paper intends to do. Mcintyre argues that provinces only need funding through the equitable share to deliver emergency health services. McIntyre, however, does not delve into much detail on the impact that these reforms will have on provincial government and the system of co-operative governance, specifically, the redirecting of the health component of the PES to the Fund. This research is aimed at contributing to such a scarcely researched area, namely the impact and constitutionality of the NHI on provincial governments, with the NHI becoming more of a reality and its implications for provinces alarming. The main issues that are dealt with in this thesis relate to the change in the administration of central hospitals, the takeover by national government of PHC services, the possible intrusion of the national government onto ambulance services and the reduction of the PES. The constitutionality of these changes are examined in chapter four. These issues have not been dealt with by other authors and therefore this thesis is aimed at contributing to such a scarcely researched area.

[80] FFC (2016) 10.
[81] FFC (2016) 11.

1.5. Chapter outline

Chapter one is the introduction to the thesis. It provides the framework of this paper. The problem statement is set out in this chapter. This is followed by the research question and preliminary arguments are made. A literature review is done to corroborate the originality of the topic pursued, together with an outline of the chapters of this thesis and this is followed by a research methodology.

Chapter two will look at the constitutional provisions relating to health services. The legal framework that has been put in place to give effect to these constitutional provisions and the way it provides health service responsibilities to each sphere will be examined. The responsibility of each sphere in practice will be addressed. The funding mechanisms for public health delivery will also be discussed.



Chapter three will look at how the NHI will work. The history and evolution of an NHI will be discussed. This is followed by the purpose for the NHI and how the NHI will work, respectively. The proposed changes by the NHI Bill will be looked at. This includes a discussion of the changes to national, provincial and local governments' current role in the health sector. The chapter will also look at how the NHI will be funded to ensure that it is enabled to carry out its proposed job as a financing system.

Chapter four will evaluate whether the NHI is constitutional. This chapter is at the crux of this thesis, as it will determine the answer to the proposed research questions and the consequences that flow from it. The assessment of the NHI's constitutionality will be done by analysing the constitutionality of proposed changes by the NHI Bill using the Constitution and case law.

Chapter five will be the concluding chapter of the thesis. Possible suggestions regarding the monitoring role of national government will be provided. Improving provinces' capacity to deliver

quality health services to communities will be suggested. Recommendations that are more in line with the spirit and values of a multilevel government system will be looked at.

1.6. Research methodology

In writing this thesis, a desktop research methodology will be used. The first point of reference will be using legal instruments namely the Constitution, legislation and case law. A variety of governmental policies relating to health will be used. This includes any commentary or submissions made by various organs of state and the public regarding the NHI that play an important role in substantiating some of the arguments in the paper or refuting the arguments. Academic texts namely, books and journal articles will be used to gain insight on different arguments posed by authors that have been written on NHI and the powers of subnational governments. Media sources such as newspapers will be used extensively, as there has been a lot written in the media on the possible impact of the NHI. In addition, focus will be on the public health sector as opposed to the private sector.

CHAPTER 2: THE CURRENT PUBLIC HEALTH SYSTEM

2.1. Introduction

In this chapter, there will be a detailed discussion of each sphere of government's role in health services. First, the constitutional framework regarding health services will be set out. Secondly, the division of powers among all spheres of government as provided in the National Health Act (NHA) will be discussed.[82] Thirdly, what happens in practice will be discussed regarding each sphere's role. Fourthly, how public health services are funded will also be discussed. Lastly, concluding remarks will be provided.

2.2. Constitutional framework

2.2.1. Right of access to health care services

The Constitution explicitly refers to health services in two parts. First, in the Bill of Rights where the right of access to health services is explicitly provided for.[83] Section 27 of the Constitution provides that 'everyone has the right of access to health care services including reproductive health…'. Section 27 places an obligation on the state to take reasonable legislative and other measures to ensure that this right is progressively realised.[84] The Constitutional Court has held that the state does not have to realise the right instantaneously but a plan should be devised and implementation measures taken to realise socio-economic rights.[85] Realising the right of access to health care does not have to be immediate, but such realisation should be worked towards. The Constitution also provides that the state should ensure that the progressive realisation of the right of access to health care services be within the state's available resources.[86] The Constitutional

[82] Act 61 of 2003.
[83] Section 27(1)(*a*) Constitution. The Constitution also explicitly mentions the rights of children to health care services in section 28(1)(*c*) and the rights of detained and imprisoned individuals to medical treatment as per section 35(2)(*e*).
[84] Section 27(2) Constitution.
[85] *Minister of Health and Others v Treatment Action Campaign and Others* (*TAC* case) 2002 (5) SA 721 (CC), para 35. *Government of the Republic of South Africa v Grootboom and Others* 2001 (1) SA 46 (CC), para 45.
[86] Section 27(2) Constitution.

Court has reiterated that this realisation is dependent on the available resources that the state has.[87] Moreover, the state encompasses all three levels of government, even though the national government has overall responsibility of ensuring that the state has complied with its obligations imposed by section 27,[88] in terms of sections 7(2) and 8(1) of the Constitution.[89]

This thesis will focus on the division of powers between national, provincial and local government regarding health services. It will not delve much into the human right of access to health care services as much has been written on the human rights perspective by academics such as Pearmain and Carstens.[90] Additionally, regional and international instruments on the right to health will not be analysed. It is recognised that it is difficult to divorce the socio-economic right of access to health care services from the division of powers regarding the provision of health care services among the three spheres. This paper therefore is not intended on doing so, however, the right of access to health care services is recognised as a watermark, it is recognised as compelling the state to realise this right but will not be the focus in this paper.

2.2.2. Functional areas of health care services

The second part in which the Constitution explicitly refers to health services is in schedule 4. The schedules, unlike the Bill of Rights, confer original powers on all three levels of government whereas the Bill of Rights places an obligation on all three levels of government to 'promote, protect, respect and fulfil' the rights provided in the Bill of Rights.[91] The Constitution confers health services on all three levels of government without delineating where each sphere's responsibility starts and ends.

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[87] *Soobramoney v Minister of Health (KwaZulu-Natal)* (*Soobramoney* case) 1998 (1) SA 765 (CC), para 11.
[88] Constitution.
[89] Pearmain DL *A Critical Analysis of the Law on Health Service Delivery in South Africa* (unpublished LLD thesis, University of Pretoria, 2004) 335.
[90] Pearmain (2004) 1-1405. Carstens P & Pearmain D 'The regulatory framework of the South African health system' (2009) 28 *Medicine and Law Journal* 91-124.
[91] Sections 7(2) and 8(1) Constitution.

Schedule 4A of the Constitution provides for concurrent powers regarding health services between national and provincial government. Steytler notes that concurrency, generally refers to both national and provincial governments having powers in the same policy field which covers various activities that are both constitutionally permitted and that exist in practice.[92] In addition, De Visser notes that within South Africa's context, concurrent powers place national and provincial government in a position where both levels have the same powers, that is legislative and executive powers, over the same functional area.[93] In terms of section 146(2) of the Constitution, where there is a conflict between national and provincial legislation regarding a schedule 4A competence, national legislation will only prevail if any of the conditions outlined in the section is met. These conditions include national legislation dealing with a matter more effectively, where national legislation deals with a matter that requires more uniformity through establishing norms and standards or national policies or where national legislation is necessary for maintaining national security or economic unity among other things.[94] Moreover, national legislation will prevail over provincial legislation where the national legislation is intended to prevent unreasonable action by a province where that action is 'prejudicial to the economic, health or security interests of another province or the country as a whole' or the action 'impedes the implementation of national economic policy'.[95] If any of these conditions are not present, provincial legislation will prevail.[96]

For provinces, exclusive power gives provinces exclusive authority in terms of schedule 5, whereas concurrent power gives provinces shared authority with national government. In terms of section 125(2)(*b*) of the Constitution, provinces are responsible for implementing all national legislation

[92] Steytler N 'The currency of concurrent powers in federal systems' in Steytler N (ed) *Concurrent Powers in Federal Systems: Meaning, Making, Managing* (2017) 1-2.
[93] De Visser J 'Concurrent powers in South Africa' in Steytler N (ed) *Concurrent Powers in Federal Systems: Meaning, Making, Managing* (2017) 225.
[94] Section 146(2)(*a*)-(*c*) Constitution.
[95] Sections 146(3)(*a*) & (*b*) Constitution, respectively.
[96] Section 146(4) Constitution.

regarding functional areas in schedule 4 or 5.[97] The NHA is an example where national government legislates and provinces implement. Moreover, provinces also have incidental powers regarding schedule 4 matters.[98] This entails powers necessary to perform their responsibilities effectively. Provinces, however, can generally, only exercise executive authority over concurrent functions if they exercised their legislative authority over that concurrent functional area.[99] Provinces also have administrative autonomy over the legislation they adopt in schedules 4 and 5 matters.[100] In short, concurrent powers empower both national and provincial government equally regarding functional areas listed in schedule 4, this includes health services.

Schedule 5A of the Constitution confers exclusive original powers on provinces also dealing with some aspects of health care services, namely, ambulance services. This means that provinces have legislative, executive and administrative authority over matters listed in this schedule, to the exclusion of the other two spheres.[101] There are however instances where national government enjoys an override, which however is qualified. In terms of section 44(2) of the Constitution, the national sphere has discretionary intervention powers regarding schedule 5 matters. It is argued that these powers are discretionary because the operative word used in the Constitution is 'may' as opposed to 'must'.[102] These intervention powers may be used by the national sphere, specifically Parliament, through the passing of legislation that is 'necessary for the maintenance of national security; maintenance of economic unity; to maintain essential national standards, to establish minimum standards for the rendering of services or to prevent unreasonable action taken by a province which is prejudicial to the interests of another province or the country as a whole'.[103]

[97] This provision is subject to the Constitution or an Act of Parliament providing otherwise. Section 125(2)(*b*) Constitution.
[98] Section 104(4) Constitution.
[99] Pearmain (2004) 340.
[100] De Visser J & May A 'Functions and powers of South Africa's provinces and municipalities' in Steytler N & Ghai YP (eds) *Kenya-South Africa Dialogue on Devolution* (2015) 157.
[101] Steytler N & De Visser J *Local Government Law of South Africa* 11 ed (2018) 5-25.
[102] Section 44(2) Constitution.
[103] Section 44(2)(*a*)-(*e*) Constitution.

This is a qualified override due to the principles of co-operative government provided in the Constitution,[104] which includes the constitutionally recognised distinctiveness of each sphere of government, which will be discussed in more detail in chapter four.

In most provinces, ambulatory services fall within emergency medical services (EMS) which is more than transportation services.[105] EMS includes acute pre-hospital care as well as ambulatory services with paramedics that usually provide acute pre-hospital care. Ambulance services have evolved from being a service for pick-ups and drop offs to a hospital and providing basic first aid, to providing acute pre-hospital care to people who are ill.[106]

The Constitution also confers original powers on local government regarding health services.[107] In terms of schedule 4B,[108] local government has legislative authority in respect of 'municipal health services'. Moreover, in terms of section 156(1)(*a*) of the Constitution, municipalities have executive authority over schedule 4B matters and the power to administer those matters. 'Municipal health services' overlap with health services listed in schedule 4A. Steytler and Fessha note two types of overlaps that can be present regarding the schedules, namely a supervisory overlap or overlaps between matters in the same schedule but different parts of the schedules.[109] This is a case of the latter. This overlap makes for unclear competencies and confusion as to where one sphere's responsibility begins and ends.[110] Moreover, Steytler and Fessha provide that the placing of 'municipal' in front of a functional area does not help in delineating the responsibilities of each sphere.[111] Aside from the definitional distinction between 'municipal health services' and

[104] Sections 40 and 41 Constitution.
[105] Van Huyssteen N *A Legal Analysis of the Emergency Medical Services in South Africa* (unpublished LLM thesis, University of Pretoria, 2016) 17.
[106] Van Huyssteen (2017) 17.
[107] Schedule 4B Constitution.
[108] Constitution 1996.
[109] Steytler N & Fessha Y 'Defining local government powers and functions' (2007) 124(2) *South African Law Journal* 320-1.
[110] Steytler & Fessha (2007) 321. Steytler & De Visser (2018) 5-19.
[111] Steytler & Fessha (2007) 321.

health services that provinces and national government are given, all three spheres have original powers conferred by the Constitution in relation to health services.

The right of access to health services has been given substantive effect through legislation.[112] The next part will look at that legislative framework, to see how each sphere is empowered to play its part regarding health service delivery in terms of the NHA.[113]

2.3. Legislative framework

There are several legislative instruments that provide a broad framework for health service provision and health-related aspects.[114] The NHA recognises that the Constitution has placed an obligation on all three spheres to play a role in health services provision.[115] Moreover, the NHA provides a narrower definition of what health services encompass. Health services in terms of the NHA refer to health care services, including reproductive health care and emergency medical treatment, basic nutrition and those health care services contemplated in section 28(1)(c) of the Constitution, medical treatment for detained and imprisoned persons and municipal health services.[116]

2.3.1. National government

The NHA provides a heading titled 'national health' in chapter three which starts off detailing the general functions of the National Department of Health (NDoH). The general functions are largely concerned with policymaking and ensuring national health policies are implemented in so far as these relate to the national government.[117] These policies must be implemented according to the guidelines issued by the Director-General (DG) of the NDoH.[118] The NDoH is also responsible for

[112] De Vos P & Freedman W (eds) *South African Constitutional Law in Context* (2014) 679.
[113] Act 61 of 2003.
[114] NHA, Health Professions Act 56 of 1974, Nursing Act 33 of 2005 amongst others.
[115] Preamble Act 61 of 2003.
[116] Section 1 Act 61 of 2003.
[117] Section 4 Act 61 of 2003.
[118] Section 21(1) Act 61 of 2003.

creating health policies and establishing norms and standards for health services for subnational governments. The NDoH, under the leadership of the national Minister for Health (the Minister), is responsible for the establishment of norms and standards for a range of health care services and procedures. Examples of these norms and standards include the eligibility requirements of the categories of persons for free health services or the prescribed information that should go on a discharge form.[119] In addition, the DG must act in accordance with national health policy when liaising with national health departments abroad.[120]

Moreover, the NDoH is responsible for overseeing and governing the national health system and supervising subnational governments regarding health service delivery.[121] This includes facilitating and promoting the provision of health services to manage, prevent and control the spread of communicable and non-communicable diseases.[122]

The DG is also responsible for preparing the medium-term health and human resource plans, annually.[123] These plans are important as they provide the strategy for how the national department will be exercising and performing its duties.[124] Moreover, these plans form the basis of the NDoH budget that will be required for the NDoH to perform its duties.[125]

In terms of section 22(2) of the NHA, a national health council which is headed by the Minister and has a mix of national, provincial and local politicians has been established.[126] This council acts

[119] Section 4 Act 61 of 2003.
[120] Section 21(2)(*a*) Act 61 of 2003.
[121] Section 3(1) Act 61 of 2003.
[122] Section 21(2)(*k*) Act 61 of 2003. Communicable diseases such as HIV/AIDS and TB. Non-communicable diseases such as heart disease and hypertension. Toyana MM *A National Health Insurance Model to Promote Universal Healthcare in South Africa* (unpublished Masters in Public Management and Governance, University of Johannesburg, 2013) 9.
[123] Section 21(3)(*a*) Act 61 of 2003.
[124] Section 21(3)(*a*) Act 61 of 2003.
[125] Section 21(3)(*b)*(i) Act 61 of 2003.
[126] Aside from the Minister or his/her nominee as the chairperson, the council consists of the deputy minister of health; MECs for health; 'one municipal council representing organised local government and appointed by a national organisation contemplated in section 163(a) of the Constitution' (in practice this organisation is the South African Local Government Association (SALGA); the Director-General (DG) and Deputy DGs of the NDoH; head of each provincial department; an employee of SALGA and the head of the South African Military health service. Sections 22(2)(*a*)-(*h*) Act 61 of 2003.

as an advisory body to the Minister regarding health policies that will help to 'protect, promote, improve and maintain the health of the population'.[127] This includes policy matters such as equitable financing mechanisms to fund health services,[128] designing and implementing effective referral systems, or coordination of health services.[129] The national health council is an important body as consultation has to take place with this council about any proposed legislation relating to health matters before such proposed legislation is introduced to Parliament or provincial legislatures.[130] The national health council must advise the Minister regarding proposed legislation. The operative word in section 23 of the NHA is 'must' in relation to advising,[131] but not necessarily on whether the Minister must heed the advice. Moreover, the council must advise the Minister on norms and standards regarding health establishments.[132] The Minister should therefore act considering the council's contributions.

The NHA also provides that a national health consultative forum should be established by the Minister.[133] This forum seems to be a communication channel regarding information on national health issues between the national department and national organisation and provincial consultative bodies, whereas the national health council advises the Minster on health-related matters.[134]

The classification of health establishments is done by the Minister.[135] The NHA provides that the Minister may regulate all health establishments into appropriate categories according to their role and function in the national health system or the nature and level of services the establishment

[127] Section 23(1)(*a*) Act 61 of 2003.
[128] Section 23(1)(*a*)(vi) Act 61 of 2003.
[129] Sections 23(1)(*a*)(vii) and (iii) Act 61 of 2003, respectively.
[130] Section 23(1)(*b*) Act 61 of 2003.
[131] Act 61 of 2003.
[132] Section 23(1)(*c*) Act 61 of 2003.
[133] Section 24(1) Act 61 of 2003. The Minister determines the composition of this forum. Section 24(3)(*a*) Act 61 of 2003.
[134] Section 24(2) Act 61 of 2003.
[135] Section 35(*a*) Act 61 of 2003.

provides, among other things.[136] Moreover, the establishment of hospital boards and management systems of central hospitals may be determined by the Minister.[137] This section however only came into effect in 2012. In addition, the Minister is responsible for determining the range of health services to be delivered at central hospitals, the referral procedures, fees for services and functions of central hospital boards.[138] The Minister does this through promulgating regulations. Moreover, the NHA also empowers the Minister to establish academic health institutions to educate and train health care personnel and health research.[139]

Furthermore, the NDoH is empowered in terms of section 3(2) of the NHA to provide health services. Evidently, the NDoH can render health services if it so pleases, in terms of both the Constitution and national legislation. However, the NDoH rarely does so, as will be seen later in this chapter.

2.3.2. Provincial government

Provincial executives are primarily tasked with adopting and implementing national legislation in areas of concurrency.[140] Legislation also confirms this role of provinces as implementers of national legislation such as the NHA.[141]

The NHA provides a heading titled 'provincial health' under chapter four.[142] It has to be noted that although the definition section of the NHA does not provide provincial health services as a category of health services as it does with 'municipal health services', chapter four explicitly provides for 'provincial health services'.[143] The legislative framework gives provinces several powers regarding health services. First, in terms of the NHA, provinces are responsible for the

[136] Section 35(*a*) Act 61 of 2003.
[137] Section 35(*b*) Act 61 of 2003.
[138] Sections 41(1), (4) and (5) Act 61 of 2003.
[139] Section 51 Act 61 of 2003.
[140] Murray C & Ampofo-Anti O 'Provincial Executive' in Woolman S & Bishop M (eds) Constitutional Law of South Africa 2 ed (2014) 20-1.
[141] Ch 4 Act 61 of 2003.
[142] Ch 4 Act 61 of 2003.
[143] Section 25 Act 61 of 2003.

implementation of national health policies and norms and standards set by the NDoH.[144] The Member of the Executive Council (MEC) for health is responsible for implementing these policies and promoting compliance with the norms and standards in their respective provinces.

Secondly, provinces are explicitly given powers in terms of the NHA for the actual provision of health services. These services include specialised hospital services,[145] EMS,[146] occupational health services and environmental pollution control services.[147] Provinces therefore are mainly responsible for the delivery of a large part of health care services, which are not necessarily primary health care (PHC). In addition, section 41 of the NHA empowers the MEC for health, in his/her respective province, to provide referral procedures regarding all public health establishments, excluding central hospitals.[148] It should be noted that the NHA provides that provincial governments deliver EMS, not mentioning the role of national and local government in EMS.

Thirdly, provincial governments are responsible for the planning and management of the provincial health information systems in their respective provinces.[149] This implies that provinces can have information systems separate from a national health information system provided they are co-ordinated with the national health information system. Moreover, section 75 of the NHA provides that a committee should be established by the MEC for health, who in turn will establish, facilitate and maintain a health information system at provincial and local level.[150] In addition, and similar to the Minister, the MEC for health is responsible for establishing procedures for laying complaints of health service users, in their respective provinces.[151]

[144] Section 25(1) Act 61 of 2003.
[145] Section 25(2)(a) Act 61 of 2003.
[146] Section 25(2)(m) Act 61 of 2003.
[147] Sections 25(2)(r) and (u) Act 61 of 2003.
[148] Section 41(1)(b) Act 61 of 2003.
[149] Section 75 Act 61 of 2003.
[150] Section 75 Act 61 of 2003.
[151] Section 18 Act 61 of 2003.

Fourthly, there are provincial health councils established in all provinces and headed by the relevant MEC or his/her nominee.[152] Provincial health councils have advisory powers. These councils advise the MEC for health, in their respective provinces, on policies that ought to respect, protect and promote the health of the respective provincial population.[153] Moreover, provincial health councils must advise the MEC for health on the norms and standards to be complied with for the creation of health establishments.[154] Furthermore, provincial health departments have a role in policy formulation at the national level, as stated above because the MECs for health are a part of the national health council. In addition, when provincial governments make health plans, those plans must comply with national health policies.[155] This is so because of the hierarchical nature of South Africa's multilevel government system.

Fifth, provinces are also tasked with the establishment of clinic committees and community health centre committees through provincial legislation, including prescribing the functions of these committees.[156] The NHA does not provide much detail about the powers of the MEC for health regarding the substantive issues such as the decision-making powers and communication channels of these committees, but merely that the MEC for health should prescribe functions to these committees.[157] According to Boulle, there has been a limited effort to formalise community health committees.[158]

Sixth, the NHA envisages that provincial governments should control the district health system (DHS) through which PHC services should be delivered, as envisaged in the *White Paper on the*

[152] Section 26 Act 61 of 2003.
[153] Section 27(1) Act 61 of 2003. Policy advising includes giving advice on the equitable provision, financing targets and priorities of health services in the respective provinces to the MEC for health.
[154] Section 27(1)(*c*) Act 61 of 2003.
[155] Section 25(4) Act 61 of 2003.
[156] Section 42 Act 61 of 2003.
[157] Boulle TM *Developing an Understanding of the Factors Related to the Effective Functioning of Community Health Committees in Nelson Mandela Bay Municipality* (unpublished Masters in Public Health, University of the Western Cape, 2007) 9.
[158] Boulle (2007) 21.

Transformation of the Health System (*White Paper on Health*).[159] This however meant that provinces got control of PHC services, which used to be provided by municipalities.[160] Provincial governments are therefore responsible for establishing district health councils,[161] providing their functions through provincial legislation and co-ordinating the financial affairs of district health councils (DHC), to name a few.[162] The DHS entails dividing provinces into smaller 'administrative' and service units called health districts.[163] These health districts coincide with metropolitan and district municipality boundaries that ought to be responsible for PHC delivery.[164] Moreover, the NHA reiterates section 156(4) of the Constitution, which obliges provinces to assign a matter that would most effectively be administered at local government level, provided municipalities have capacity to administer such matters.[165] This includes health services. The delivery of PHC services is the main activity of provincial health departments, which is done through a DHS.[166] Initially, PHC services were to be provided by local government. The proximity of local government to the community puts local government in the opportune position to identify and assess the needs of the community.[167] However, the reality of municipalities failing to deliver services (adequate or at all) should be borne in mind, as they also lack capacity and have poor administrative skills.[168]

Seventh, provincial governments are also responsible for the provision of ambulance services in their respective provinces.[169] Ambulance services are regulated by provincial legislation, with provinces having exclusive powers over these services.[170] Interestingly, the Free State Provincial

[159] *White Paper on Health* (published in *GG* 17910 of 1 July 1997).
[160] Steytler & De Visser (2018) 5-24.
[161] Section 31(1) Act 61 of 2003.
[162] Sections 31(5)(*a*) and 25(2)(*d*) Act 61 of 2003, respectively.
[163] Brauns M *Public Healthcare in a Post-Apartheid South Africa: A Critical Analysis in Governance Practices* (unpublished PhD in Policy and Developmental Studies, University of KwaZulu-Natal, 2016) 107.
[164] May (2015) 497 & 508.
[165] Section 32(2) Act 61 of 2003.
[166] Rispel (2016) 18.
[167] May (2015) 482.
[168] May (2015) 503.
[169] Schedule 5A Constitution.
[170] Schedule 5A Constitution.

Health Act regulates EMS inclusive of ambulatory services.[171] The Western Cape Ambulances Act, on the other hand, specifically provides for the administration and operation of ambulance services as opposed to an all-encompassing EMS as the Free State does.[172] Moreover, the Constitutional Court in *Soobramoney v Minister of Health* has also included ambulance services as part of the broader emergency services.[173] Emergency vehicles consists largely of ambulances.[174]

The NHA does to a certain extent provide more clarity as to the role of national and provincial government, as opposed to the Constitution, which confers the vaguely defined health services to both national and provincial government.

2.3.3. Local government

The NHA provides municipalities with a limited role of providing 'municipal health services'. The NHA has provided some definitional clarity that municipal health services are limited to environmental health services.[175] In terms of section 1 of the NHA, environmental health services include 'water quality monitoring, food control, waste management, health surveillance of premises, surveillance and prevention of communicable diseases, excluding immunisations, vector control, environmental pollution control, disposal of the dead and chemical safety'.[176] This definition establishes the role of municipalities as being more involved in non-personal health care (such as the environment) as opposed to personal health care. May submits that environmental health is not merely about treating a disease, which happens at hospitals, but also about the broader society where people live and work and community environments that affect the health of the

[171] Act 8 of 1999.
[172] Act 3 of 2010.
[173] *Soobramoney* case, para 20.
[174] Stein C, Wallis L & Adetunji O 'Meeting national response time targets for priority 2 incidents in an urban emergency medical services system in South Africa: More ambulances won't help' (2015) 105(10) *South African Medical Journal* 841.
[175] Section 1 Act 61 of 2003.
[176] Act 61 of 2003.

people.[177] Moreover, municipal health services are essential basic services that municipalities are constitutionally obligated to deliver.[178]

Despite the limited role of municipalities in personal health care, the DHS has been envisaged as the main driver for PHC delivery through policy and legislation.[179] The time has long passed where local government was merely confined to powers given in terms of statute and which can easily be retracted through an amendment.[180] Under the current constitutional dispensation, local government has been recognised as a distinctive sphere, no longer the administrative arm of national and provincial governments.[181] Since transitioning into a democracy, legislation and policies regarding public environmental health increased.[182] Local government plays a major role in health service delivery even if it is mostly confined to environmental health services.

Moreover, local government is required to participate in community health committees.[183] Even though these committees are established by provinces as mentioned above, the NHA does provide for local government to be included in health affairs that affect them. The NHA, however, does not provide a list of specific circumstances of health affairs that are likely to affect local government.

In theory, the DHC, with locally elected representatives having a seat within these structures, provides ample opportunity for promoting co-operative governance and the co-ordination of municipal health budgets and provision of health services, amongst other things.[184]

[177] May A 'Environmental health and municipal public health services' in du Plessis A (ed) *Environmental Law and Local Government in South Africa* (2015) 482.
[178] May (2015) 525.
[179] *White Paper on Health* (published in *GG* 17910 of 1 July 1997).
[180] Steytler & De Visser (2018) 1-12.
[181] Steytler & De Visser (2018) 1-8.
[182] Mathee A 'Environment and health in South Africa: Gains, losses, and opportunities' (2011) 32(1) *Journal of Public Health Policy* 41.
[183] Boulle (2007) 7.
[184] Boulle (2007) 26.

2.4. Practice

2.4.1. The role of national government in practice

Giving effect to the NHA, the NDoH is primarily concerned with 'stewarding'[185] the national health system, as opposed to delivering health services.[186] Evidently, in setting these norms and standards, the NDoH also monitors the implementation of national health legislation and national health policies.[187]

Health policy has shifted from tertiary health care, namely curative hospital services to PHC, namely preventative care and health promotion.[188] There seems to be a disconnect however, between national health policy and reality, because of a misalignment of these policy aspirations, the resources allocated and the capacity of PHC facilities and community health workers.[189] The school of public health (SOPH) contends that in practice, policymakers and often the implementers, are not critical of the nature of the health interventions they are involved in.[190]

The NDoH has identified the waiting times in public health facilities as a policy area that should be investigated and reduced.[191] The NDoH also sets annual targets for provinces such as expenditure per patient, per day, or hospital inpatient bed utilisation, to name a few.[192] In addition,

[185] See section 1.1 ch 1.
[186] Serfontein J 'State takeover of academic hospitals is not the answer' *BusinessDay* 12 July 2019 9.
[187] Doherty J 'Increasing tax revenue and its impact on financing public health care in South Africa' *ResearchGate* 2015 available at *https://www.researchgate.net/publication/280551537* (accessed 9 September 2019) 65.
[188] School of Public Health (SOPH) 'Annual Report' *SOPH* 2005-2006 available at *https://www.uwcsoph.co.za/index.php/about/annual-reports* (accessed 29 August 2019) 5. This SOPH is a faculty at the University of the Western Cape which focuses on PHC, district health management among other things. Several universities across South Africa also have SOPH.
[189] Financial and Fiscal Commission (FFC) *Policy Brief: Recentralisation - Implications for Service Delivery and Intergovernmental Relations in South Africa* (2019) 6.
[190] SOPH (2005-2006) 2.
[191] Egbujie BA, Grimwood A, Mothibi-Wabafor EC et al 'Impact of "ideal clinic" implementation on patient waiting time in primary healthcare clinics in Kwa-Zulu Natal Province, South Africa: A before-and-after evaluation' (2018) 108(4) *South African Medical Journal* 311.
[192] Najjar L *Bed Utilisation Trends in Selected Wards across Eight District Hospitals in the Cape Town District* (unpublished Masters in Public Health, University of the Western Cape, 2018) 12.

the NDoH also sets national response time targets for EMS performance by provinces, to measure provinces performance in relation to EMS.[193]

The NDoH is responsible for the procurement of medicines, particularly anti-retrovirals (ARVs).[194] In 2011, the NDoH took over the procurement of ARVs and other medicines from the national treasury,[195] who used to procure medicines. Prior to the NDoH taking over the procurement, the national treasury's procurement processes were described as weak because of the high costs at which the national treasury purchased medicines.[196] Based on this extended procurement role, it is evident that the NDoH continues to broaden its role in health services. According to Magadzire's research, nationalising the procurement of medicines is fraught with delays in pharmaceutical tenders and absence of national contracts for several essential medicines. Magadzire further contends that these inefficiencies at national level, contribute to the stock-outs at provincial level.[197] In 2015, the NDoH redirected the governance and control of the National Laboratory Health Services (NHLS) to itself. The NHLS used to be a state entity but the state did not exercise direct control over it.[198] The NHLS was an independent body that made its own business decisions.[199]

2.4.2. The role of provincial government in practice

Provinces are largely responsible for the actual delivery of health care services. Provincial health departments currently deliver every level of health care i.e. primary (which was provincialised in 2009),[200] secondary, tertiary and specialised. The different levels of care are delivered through

[193] Stein, Wallis & Adetunji (2015) 840.
[194] Doherty (2015) 54.
[195] Pharasi B & Miot J 'Medicines selection and procurement in South Africa' in Padarath A & English R (eds) *South African Health Review* (2013) 181.
[196] Doherty (2015) 54.
[197] Magadzire BP *Understanding the Dynamics of Accessing Chronic Medicines in the Public Sector: Implications for Policy in South Africa* (unpublished PhD in Public Health, University of the Western Cape, 2016) 48.
[198] FFC (2018) 48.
[199] Pearmain (2004) 466.
[200] May (2015) 510.

different categories of public health establishments in a hierarchical manner that starts with clinics and community health centres (CHCs), district, regional, tertiary, central and specialised hospitals.[201] The more clinically intense the treatment required, the higher up the hierarchy a patient goes.[202]

In 2009, PHC services were also transferred to provinces as the DHS lacked decentralised managerial powers. Provincial governments have been reluctant to decentralise decision-making authority to municipalities for PHC delivery partly due to the backlogs and fragmentation of apartheid-inherited health system.[203] Provinces have also been slow in establishing DHCs, and where they have established them, decision-making and management authority has not been decentralised to these councils.[204] As a result, district municipalities were stripped of their function regarding PHC services. PHC services are generally delivered through clinics and CHCs. PHC facilities are required to deliver preventative, promotive, curative and rehabilitative services.[205] PHC services in South Africa are a nurse-driven system.[206] This means that there are few doctors present at PHC level.

District hospitals support PHC and are managed by district municipalities, but are owned by provinces.[207] District hospitals play a crucial role in supporting the delivery of PHC services and are the entry point to more specialised care.[208] District hospitals primarily deal with acute and

[201] Regulations Relating to Categories of Hospitals in GN 185 *GG* 35101 of 2 March 2012, 3.
[202] Von Holdt K & Murphy M 'Public hospitals in South Africa: Stressed institutions, disempowered management' in Buhlungu S, Daniel J, Southall R (eds) et al *State of the Nation: South Africa 2007* (2007) 313.
[203] South African Local Government Association (SALGA) *Position Paper on the Provincialisation of Personal Primary Health Care Services* (2009) 12.
[204] Boulle (2007) 26.
[205] Magadzire (2016) 14.
[206] Moosa S, Luiz J, Carmicheal T et al 'Insights of private general practitioners in group practice on the introduction of national health insurance in South Africa' (2016) 8(1) *African Journal on Primary Health Care and Family Medicine* 1.
[207] Shivani, Adams & Burger (2017) 102.
[208] Najjar (2018) 5.

simple illnesses.[209] Where illnesses are more complicated, a patient is usually referred to a regional or tertiary hospital.[210]

Secondary health services are delivered through hospitals, namely regional hospitals that are owned by provinces. Services provided at regional hospitals include paediatrics, gynaecology and general surgery.[211]

Tertiary and quaternary health services are delivered through tertiary and central academic hospitals. There have been recent calls to nationalise central academic hospitals, as these hospitals are currently owned by provinces despite the name 'central'.[212] Central hospitals are also used as training hubs for health professionals. Although central hospitals are owned by provinces, they operate at a national level by providing both general and specialised care inter-provincially.[213] The logistics and supply chain of central hospitals are a provincial competence. According to Serfontein, these functions would need to be duplicated at national level if nationalised.[214] Approximately thirty billion rand is currently being spent to run central hospitals.[215] These central hospitals are reportedly being mismanaged.[216]

Specialised hospitals provide specialised services such as psychiatry, or for illnesses such as tuberculosis (TB).[217] South Africa has a quadruple burden of disease, with TB being one of the main causes of death in South Africa.[218] The Western Cape has one of the highest prevalence of TB among the nine provinces.[219]

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[209] Najjar (2018) 9.
[210] Najjar (2018) 9.
[211] Reg 4(1) *GG* 35101 of 2 March 2012.
[212] Serfontein (2019) 9.
[213] Shivani, Adams & Burger (2017) 102.
[214] Serfontein (2019) 9.
[215] Serfontein (2019) 9.
[216] Serfontein (2019) 9.
[217] Reg 7 *GG* 35101 of 2 March 2012.
[218] Smith A *Healthcare Reform Priorities for South Africa: Four Essays on the Financing, Delivery and User Acceptability of Healthcare* (unpublished PhD in Economics, Stellenbosch University, 2016) 75.
[219] Smith (2016) 81.

Moreover, provinces also own most of the public health establishments through which health care services are delivered which consist of most clinics, CHCs and all public hospitals.[220] As a result, provincial health departments directly employ their health workforce and remunerate the health workforce from the provincial budgets. Provinces also contract private general practitioners (GPs) to provide services in the public health sector through capitation contracts.[221] Contracted private GPs either work in public clinics and get paid an hourly rate or they offer free immunisations at the expense of the public system.[222] Provincial governments however, are notorious for not being willing to pay these private GPs.[223]

2.4.2.1. Major challenges

There are major challenges present in the public health sector. First, there are deep inequalities present in the hospital sector in South Africa. There is a skewed distribution of suitably qualified health practitioners across more urban provinces such as Western Cape and Gauteng as opposed to rural provinces such as Limpopo.[224] Secondly, there is also poor quality of health delivered as public institutions lack key equipment and/or drugs.[225] The distribution of medicines falls within the ambit of provinces. There have been countless reports about medicine stock-outs at public health facilities, which exacerbate poor health outcomes.[226] Moreover, there is a lack of skilled and adequately trained staff, which also affects the quality of health service provision.[227] With PHC being nurse-driven, most provinces have had a decrease in professional nurses, which in turn threatens service delivery.[228] Thirdly, the public system operates on a referral model put in place

[220] Shivani, Adams & Burger (2017) 102.
[221] Capitation contracts in the health sector entail agreements where a GP provides specific services to patients and is remunerated based on the number of services the GP provided. Klinck E 'Summarised highlights of the latest amendments to the regulations of the Medical Schemes Act: Part II' (2003) 93(2) *South African Medical Journal* 105.
[222] Moosa, Luiz & Carmicheal (2016) 1.
[223] Moosa, Luiz & Carmicheal (2016) 5.
[224] Pearmain (2004) 868.
[225] SOPH (2005-2006) 2.
[226] Magadzire (2016) 48.
[227] Pearmain (2004) 868.
[228] Ministry for Health *Draft for Discussion: A Strategic Framework for the Human Resources for Health Plan* (2015) 26.

by the MEC. These referral pathways are, however frequently bypassed by patients and health professionals.[229] Fourth, in provincial annual reports, provinces tend to submit that they comply with national EMS response time targets, however, when these reports have been reviewed it was evident that the urban areas in provinces such as Gauteng and Western Cape have not met the national targets between 2013-2015.[230] These provinces have, however, shown improvement.[231] Other provinces seem to have digressed in achieving national targets, largely due to the lack of operational vehicles available.[232] As a result of these challenges faced mainly by provinces in running health services, the NHI has been proposed.

2.4.3. Role of local government in practice

District and metropolitan municipalities are envisaged to be the main drivers of PHC services. Metropolitan municipalities delivered PHC services prior to the enactment of the NHA. The reality of a DHS however, proved to be futile, particularly for district municipalities with provinces not decentralising management authority to district health managers.[233] In addition, the district health information system was adopted as the official information system in all the health districts within the provinces, for the reporting and monitoring of health services.[234] However, the DHS and therefore the district health information system presented an enormous challenge as huge amounts of training and mentoring were required in order to implement and sustain the system.[235]

Since metropolitan municipalities retained the power to provide PHC services, they also own some public clinics.[236] Certain metropolitan municipalities work in conjunction with provincial

[229] Shivani, Adams & Burger (2017) 104.
[230] Stein, Wallis & Adetunji (2015) 840.
[231] Stein, Wallis & Adetunji (2015) 840.
[232] Stein, Wallis & Adetunji (2015) 840.
[233] Rispel (2018) 18.
[234] SOPH (2005-2006) 31.
[235] SOPH (2005-2006) 31.
[236] An example of a metropolitan municipality is the City of Cape Town that delivers health services to approximately 84% of Cape Town's population. The district services delivered by the City of Cape Town includes home and community based care, PHC, district and specialist hospital care and regional care. Najjar (2018) 10.

departments of health to deliver PHC services, such as the City of Cape Town. In the Johannesburg Metropolitan Municipality, CHCs are managed by provincially appointed managers, whereas clinics are managed by municipal managers which are smaller than CHCs.[237] Both provinces and certain categories of municipalities provide PHC services which results in duplication of the services.[238]

Local government, however, is limited to providing environmental health services. These services are allocated to district and metropolitan municipalities and to some extent local municipalities as part of the basic services that municipalities are required to deliver.[239] As municipal health services have been narrowly defined through a statute, only metropolitan municipalities deliver PHC services in the local government sphere.[240] Moreover, municipalities play a role in providing water and sanitation services to the health establishments within their territorial boundaries.

2.5. Funding of public health

As a result of the past system of apartheid, the inequitable health policies and curative-focused care, the health sector became expensive.[241] Currently, public and private health expenditure in South Africa is said to be the second highest on the continent.[242] Public health care is funded largely through taxes, which are levied by Parliament and divided annually among all three spheres of government by the national treasury, through a division of revenue process. The fiscal space for public health care, however, is shrinking.[243]

[237] Moosa, Derese & Peersman (2017) 4.
[238] Moosa, Derese & Peersman (2017) 5.
[239] Agenbag M 'Recognising the role of environmental health in the public health fraternity: A South African perspective' *ResearchGate* February 2015 available at *https://www.researchgate.net/publication/281235480* (accessed 9 September 2019).
[240] May (2015) 510.
[241] Lalloo R *Equity and the Allocation of Health Care Resources at District Level- Lessons from a Case Study in Mitchells Plain* (unpublished Masters in Dentistry, University of the Western Cape, 1994) 9.
[242] Moosa, Derese & Peersman (2017) 6.
[243] Doherty (2015) 7.

Delivery of health services is one of the main expenditures of provincial government.[244] Provinces spend a third of their budget on health services.[245] With provinces having substantial powers regarding the actual delivery of a range of health services, funding is essential to enable provinces to provide all these services. Provinces, however, have a limited tax base. The Constitution provides that provincial legislatures may impose taxes, levies and duties excluding taxes such as 'income tax, VAT, general sales tax, rates on properties or customs duties'.[246] Provincial legislatures can also impose surcharges on tax, levy or duty that national legislation imposes.[247] Provinces, therefore, rely on funding from the national fiscus to deliver health services. Provincial health departments currently receive one hundred and fifty billion rand from the treasury to provide health services.[248] Funds for public health service delivery are determined by a formula known as the provincial equitable share (PES) and transferred from the national treasury to provincial treasuries. Provinces have gained considerable autonomy in deciding how to spend their funds since the introduction of fiscal federalism in 1993,[249] despite the constrained fiscal space.[250]

Most of provincial government funding is through transfers from the national fiscus. The Constitution requires the annual division of nationally raised revenue among the three spheres of government.[251] This division is done through the adoption of the annual Division of Revenue Act (DORA) and the nationally collected revenue should be divided equitably.[252] In addition, section 214(2) of the Constitution provides some factors which should be considered before enacting

[244] Steytler N 'Federal homogeneity from the bottom up: Provincial shaping of national HIV/AIDS policy in South Africa' (2003) 33 (1) *Publius: The Journal on Federalism* 61.
[245] FFC *Submission for the Division of Revenue 2019/20: Provincial Fiscal Adjustment Mechanisms in Times of Protracted Fiscal Constraints – Case of the Health Sector* (2018) 62.
[246] Section 228(1)(*a*) Constitution.
[247] Section 228(1)(*b*) Constitution.
[248] Paton C 'Provinces ask for caution on national health insurance' *BusinessDay* 23 August 2019 2.
[249] Under the Interim Constitution and finalised in terms of the final Constitution of 1996. Khumalo B, Dawood G & Mahabir J 'South Africa's intergovernmental fiscal relations system' in Steytler N & Ghai YP (eds) *Kenya-South Africa Dialogue on Devolution* (2015) 201-202.
[250] Doherty (2015) 50.
[251] Section 214(1)(*a*).
[252] Section 214(2) Constitution.

DORA.[253] These factors are important as they help navigate the division while taking into consideration the constitutional design of the three spheres of government.[254] Due to the provincial budgets having to be looked at through the 'prism of national objectives',[255] provincial budgets generally have to be reconciled with the national treasury's plan and the medium-term expenditure framework (MTEF).[256]

Unlike provinces, municipalities have a more substantial tax base. Municipalities can tax property and impose surcharges on the services they provide.[257] Generally, municipalities use their own revenue to pay for the services they deliver, such as environmental health services, but the Constitution still entitles municipalities to a share of the nationally collected funds, because not all municipalities have the same revenue-generating capacity.[258]

2.6. Conclusion

Having a constitutional order that entrenches devolution and other forms of decentralisation, means that the past discriminatory practices regarding funding and provision of health services are never repeated, as the law-making and provision of health services is not concentrated in national government. All three spheres of government play in a role in health services through powers conferred by the Constitution and in terms of the NHA. Currently, national government is largely responsible for stewarding the national health system, as opposed to delivering health services. Provinces are responsible for the delivery of health services, a major socio-economic functional area. Local government has a fair role regarding PHC services, particularly metropolitan

[253] Important factors include:
> '*d*) the need to ensure that the provinces and municipalities are able to provide basic services and perform the functions allocated to them;
> *e*) the fiscal capacity and efficiency of the provinces and municipalities;
> *f*) developmental and other needs of provinces, local government and municipalities… .'

[254] Khumalo, Dawood & Mahabir (2015) 211.
[255] De Vos (2014) 307.
[256] Doherty (2015) 61.
[257] Section 229(1) Constitution. Khumalo, Dawood & Mahabir (2015) 206.
[258] Section 227(1)(*a*) Constitution.

municipalities. Local government's role is largely limited to the non-personal aspects of health such as environmental health.

Subnational governments generally have limited autonomy regarding specific functional areas. Health services however seem to be the exception for provinces in particular. Since provinces play such a huge role in the delivery of health services and having such a limited tax base, they receive most of their funding from the national fiscus. There has not been much opposition to resource allocation in the past, however, this could change under the proposed NHI. The NHI will be discussed in greater detail in chapter three.

CHAPTER 3: THE NATIONAL HEALTH INSURANCE

3.1 Introduction

The NHI will be a public financing system that will collect revenue and use that revenue to purchase health services from both the public and private health sectors.[259] First, the chapter will look at the history and evolution of an NHI in South Africa. Secondly, the purpose of this NHI and basis of the NHI's mandate will be discussed. Thirdly, how will the NHI work? Fourthly, the proposed changes through the NHI to each sphere of government relating to health services will be discussed. Fifth, the funding components for the NHI Fund (Fund) to carry out its proposed function as a financing system will be examined. Sixth, some of the major criticisms of the NHI, will be provided. Seventh, some concluding remarks will be made.

3.2. History and evolution of a National Health Insurance

3.2.1. The Alma Ata Declaration of 1978

In 1978, the World Health Organisation (WHO) in conjunction with the United Nations Children Fund (UNICEF), held a conference in Alma Ata, Russia on primary health care (PHC), and adopted the Alma Ata Declaration. In this Declaration, the attainment of the highest level of health is recognised as one of the most important social goals worldwide.[260] WHO and UNICEF called on national governments throughout the world to develop and implement a PHC-driven system in their respective countries, and to achieve universal health coverage (UHC) through a PHC-driven system.[261] The Declaration describes PHC as 'essential health care' that is based on 'practical, scientifically sound and socially acceptable methods and technology'.[262] This 'essential health care' has to be universally accessible to all individuals, with communities participating in their

[259] See section 1.1 ch 1.
[260] World Health Organisation (WHO) *Alma Ata 1978 Primary Health Care* (1978) 3.
[261] WHO (1978) 6.
[262] Clause VI WHO (1978) 3.

health needs. The 'essential health care' has to be affordable for the community and country as a whole to maintain at all stages of the individual and family development.[263] This means that everyone should have equal access to health care, at a cost that is not burdensome to them or the state.[264] The Declaration goes further to provide that PHC is the first level of contact that individuals and communities will have with the national health system.[265] Moreover, Clause VII of the Declaration provides seven features of PHC. First, PHC reflects a country's circumstances, that is, a country's economic, social and political characteristics. Secondly, PHC addresses the main health problems in the community, that is, 'preventative, promotive, curative and rehabilitative services accordingly'. Thirdly, at a minimum, PHC includes health education, adequate water and sanitation and immunisations, among other things. Fourthly, a PHC-driven health system requires the co-ordination of health-related sectors and aspects of national and community development such as the agriculture sector or education sector to name a few. Fifth, community involvement is required in the planning, operation and control of PHC. Sixth, the referral systems should be structured, functional and integrated, leading to progressive improvement of health care for all. Seventh, there should be suitably trained health teams at local levels.

The Declaration recognises that PHC is the key to attaining a socially and economically productive life for communities.[266] The PHC approach was re-affirmed in 2008 on the thirtieth anniversary of signing the Alma Ata declaration.[267] Bisht argues that each country has interpreted universalism

[263] Clause VI WHO (1978) 3.
[264] WHO *Primary Health Care Programme in the WHO African Region from Alma Ata to Ouagadougou and beyond* (2018) 2.
[265] Clause VI WHO (1978) 3.
[266] WHO (1978) 3.
[267] South African Local Government Association (SALGA) *Position Paper on the Provincialisation of Personal Health Care Services* (2009) 10.

differently, which results in shifts in the meaning of UHC and what that means for each country, considering that country's history and circumstances.[268]

3.2.1.1 Additional international instruments

In 2000, the Millennium Development Goals (MDGs), adopted by the United Nations (UN), were aimed at achieving important social priorities such as eliminating poverty, hunger and disease.[269] The MDGs, are not legal commitments, rather a combination of moral and practical commitments.[270] Moreover, the MDGs promoted a health-related agenda to be attained by 2015, particularly a PHC-driven health system, as most countries had failed to realise 'Health for All by 2000'.[271] The MDGs were superseded by the Sustainable Development Goals (SDGs) which were released in 2015.[272] Moreover, the UN adopted UHC as one of the goals of the SDGs. It is an important component of the SDGs and compels South Africa to reach this goal, as South Africa has adopted the SDGs.[273] Moreover, South Africa has decided to be one of the countries that voluntarily report to the UN regarding their progress on its attainment of UHC, which could explain the rush to implement the NHI.[274] Through the ratification of the Alma Ata Declaration and the adoption of the SDGs, South Africa has embarked on this journey of achieving UHC through the proposed NHI. The proposed NHI can also be regarded as an attempt by South Africa to comply with its obligations under the International Covenant on Economic, Social and Cultural

[268] Bisht R 'Universal health care: The changing international discourse' (2013) 57(4) *Indian Journal of Public Health* 236-7.
[269] Sachs JD 'From millennium development goals to sustainable development goals' (2012) 379(9832) *The Lancet Journal* 2206.
[270] Sachs (2012) 2210.
[271] SALGA (2009) 11.
[272] Gaffney O 'Sustainable development goals: Improving human and planetary wellbeing' (2014) 82 *Global Change* 20.
[273] Government Communications 'Statement on the cabinet meeting of 10 July 2019' available at *https://www.gov.za/speeches/statement-cabinet-meeting-10-july-2019-11-jul-2019-0000* (accessed 12 July 2019).
[274] Government Communications (2019) 4.

Rights (ICESCR)[275] which South Africa has signed and ratified.[276] An NHI scheme has been long anticipated in South Africa as shown below.

3.2.2. Health care delivery in South Africa pre-1994

In 1935, an NHI scheme was recommended in South Africa. However, such a scheme, if it were to be implemented, would have been limited to whites only.[277] This recommendation however, was not followed with action. During the period of 1942-44, the then Minister of Health, Dr Henry Gluckman, recommended the imposition of a tax to fund health services.[278] Health services were going to consist of community centres and general practitioners (GPs) and would be free for all at the point of care (a concept similar to the proposed NHI).[279] The paperwork was put in place for this tax and the proposal was accepted. However, Gluckman's vision was cut short when the apartheid government took over.[280] Before the institution of apartheid, there were grassroots attempts of a PHC-centred health system.[281] Under the apartheid government's rule, health care (among other things) became segregated according to racial classification. Moreover, the PHC-centred model deteriorated as the apartheid government was not fond of the tax burden that the upper class white people would have to endure to implement this model, leaving non-white South

[275] 1966 United Nations General Assembly Resolution 2200A (XXI) (1966). The ICESCR recognises health as a fundamental right and obliges state parties to the ICESCR to take steps to achieve the 'highest attainable standard of physical and mental health' and environmental health for everyone. Article 12 ICESCR, 1966.
[276] South Africa signed the ICESCR in 1994 but the covenant was only ratified in 2015 by the South African government. Dullah Omar Institute 'Press release: South African civil society organisations submit a parallel shadow report to the United Nations Treaty Body on the implementation of socio-economic rights' available at *https://dullahomarinstitute.org.za/news/press-release-south-african-civil-society-organisations-submit-a-parallel-shadow-report-to-the-united-nations-treaty-body-on-the-implementation-of-socio-economic-rights* (accessed 8 March 2020).
[277] Brauns M *Public Healthcare in a Post-Apartheid South Africa: A Critical Analysis in Governance Practices* (unpublished PhD, University of KwaZulu-Natal, 2016) 75.
[278] Mayosi BM, Lawn JE, Van Niekerk A et al 'Health in South Africa: Changes and challenges since 2009' (2012) 380 (9858) *The Lancet Journal* 2036.
[279] Brauns (2016) 75.
[280] Brauns (2016) 75.
[281] Maillacheruvu P & McDuff E 'South Africa's return to primary care: The struggles and strides of the primary health care system' available at *https://www.ghjournal.org/south-africas-return-to-primary-care-the-struggles-and-strides-of-the-primary-health-care-* (accessed 13 September 2019) 1.

Africans without access to adequate primary care.[282] In addition, the private health sector started expanding, as the apartheid government deregulated public health care.[283]

3.2.3. Health care delivery in South Africa post- 1994

Fast forward to when South Africa became a democracy in 1994, the ANC-led government published several policies in which the government envisaged the transformation of the entire health sector. A key policy instrument for health transformation in 1994 was the Reconstruction and Development Programme (RDP).[284] The RDP placed emphasis on the establishment of a district health authority (DHA) to be responsible for the delivery of all PHC services and the district health system's (DHS) health budget.[285] Regarding the health service financing system, the RDP provided that there should be a budgetary shift from curative hospital services to PHC services.[286] Since the achievement of UHC was through a PHC-driven system, the RDP framework moved South Africa a step forward to be on par with international standards, at least on paper.[287]

Transformation was underway and the realisation of UHC seemed more attainable with the release of a policy that would change the landscape of the health sector and health service delivery, that is, the *White Paper for the Transformation of the Health System (White Paper on Health)*.[288] The *White Paper on Health* continues to be an important health policy, as it sets out the vision of a PHC-centred health care delivery system. The DHS would be the driver of PHC services.[289] The decentralisation of management authority to health districts was envisaged to make the DHS successful. However, the reality of the vision of the DHS, as discussed in the previous chapter,

[282] Maillacheruvu & McDuff (2019) 1.
[283] Maillacheruvu & McDuff (2019) 3.
[284] African National Congress (ANC) *The Reconstruction and Development Programme (RDP): A Policy Framework* (1994).
[285] Clause 2.12.5.6 *RDP* (1994) 48.
[286] Clause 2.12.11.1 *RDP* (1994) 54.
[287] Wayburne (2014) 10.
[288] Ministry for Health *The White Paper for the Transformation of the Health System in South Africa (White Paper on Health)* (published in *GG* 17910 of 1 July 1997).
[289] Ministry for Health (1997) 7.

became a pipe dream as the DHS was marked by poor management, weak infrastructure and weak governance.[290] Brauns argues that South Africa's policies are some of the best in the world, but South Africa struggles in implementing these policies, and the *White Paper on Health* is an example.[291] Twenty-five years into democracy, gaps between policy and implementation are still present.[292]

In 2009, discussions of an NHI were sparked again. District municipalities were failing to deliver PHC services as envisaged. Provincial health departments controlled the DHS budget allocations and were reluctant to decentralise management authority to health districts. It was time for another transformation to take place, and at the forefront of the national government's agenda was an NHI. The ANC had taken a resolution that the public health system needed to be strengthened and adequate funding for health services was needed.[293] In 2009, the ANC formulated an NHI policy that it envisaged would bring about changes to the current public health system. A Green Paper on the NHI was released in August 2011, by the national Minister of Health (Minister).[294] This Green Paper set out the NDoH's plan to reform the health sector, yet again. The Green Paper provided a solution to transform health care delivery by making the health sector more equitable and sustainable. This transformation included a pilot NHI project through the strengthening of PHC services and delivery.[295]

There were 11 NHI pilot sites, rolled out across the nine provinces, with each province having one pilot site except for KwaZulu-Natal that had three.[296] As originally envisaged after the fall of apartheid, a district-based approach, of PHC was implemented and carried out at these pilot

[290] Lemaitre J & Young KG 'The comparative fortunes of the right to health in South Africa' (2013) 26 *Harvard Human Rights Journal* 206.
[291] Brauns (2016) 67.
[292] Brauns (2016) 105. See section 2.4 ch 2.
[293] African National Congress (ANC) *52nd National Conference: Resolutions* (2007).
[294] Policy on National Health Insurance (Green Paper on the NHI) (GN 657 in *GG* 34523 of 12 August 2011).
[295] Brauns (2016) 78.
[296] Clause 2.2.1 Ministry for *Health National Health Insurance Bill* (*NHI Bill*) (published in *GG* 42598 of 26 July 2019) 47. Brauns (2016) 78.

sites.[297] The substance of the PHC approach was to have health services closer to communities, as the first point of care that a patient receives, and would be referred to more specialised care if needed.[298] Moreover, PHC includes preventing illness through health education.[299] These district sites were launched in 2012.[300] According to South Africa's National Development Plan (NDP), a plan aimed at eliminating poverty and reducing inequality by the year 2030, free health care for all is envisaged by 2030.[301]

The NHI pilot sites also brought some issues to the forefront such as the shortage of doctors and specialists in the health sector and the critical state of health infrastructure.[302] These pilot sites were funded through a National Health Insurance (NHI) indirect grant.[303] The purpose of the grant was to address the capacity constraints in provinces and improve spending and performance of the pilot sites.[304] In addition, in 2018, the national treasury added R166 million to the NHI indirect grant for the procurement of medical equipment and the design of a new academic hospital in Limpopo.[305]

Additionally, after much consultation, a White Paper on the NHI was released in 2015 and subsequently a revised White Paper on the NHI was released in June 2017, after much consultation and uncertainty regarding how the NHI would work and how it would be funded. The NHI Bill was subsequently drafted, one in 2018 and a revised one that was tabled in August 2019 in Parliament.

[297] National Planning Commission *National Development Plan 2030: Our Future – Make it Work (NDP)* (2012) 52.
[298] Maillacheruvu & McDuff (2019) 2.
[299] Maillacheruvu & McDuff (2019) 2.
[300] NDoH *Status of the NHI Pilot districts - 12 month progress report* (2015) 1.
[301] NDP (2012) 51.
[302] NDoH (2015) 19.
[303] Ministry of Finance *The Division of Revenue Bill* (*DOR Bill*) (published in *GG* 40610 of 10 February 2017) 144.
[304] *DOR Bill* (2017) 144.
[305] National Treasury *Medium Term Budget Policy Statement* (2018) 33.

3.3. The purpose of the National Health Insurance and its mandate

3.3.1. The purpose of the National Health Insurance

The NHI is aimed at transforming the current health sector by changing the way health services are financed, purchased and provided.[306] Redressing the inequalities present in the current health sector to enable all South Africans, irrespective of their socio-economic status, so they have access to quality care and receive it free at the point of care, is paramount for the NHI scheme.[307] Moreover, through having an NHI scheme, the NHI Bill aims to achieve universal access to quality health services.[308]

3.3.2. The basis of the National Health Insurance

The NHI derives its mandate from section 27 of the Constitution, which places a positive obligation on the state to progressively realise the right of access to health care services including reproductive health.[309] Although the NHI derives its mandate from the Constitution, the NHI or a similar policy has been suggested in South Africa that predates our democracy.[310]

The NHI is based on justice, social solidarity, affordability and effectiveness. In the context of the proposed NHI scheme, social solidarity refers to the financial risk pooling to allow the NHI Fund (Fund) to cross-subsidise between the rich and the poor or the healthy and the sick.[311]

Moreover, there are various influences and rationales for implementing the NHI scheme in South Africa, from the discriminatory health policies and laws of apartheid, the Alma Ata Declaration, ICESCR and policies such as the RDP and *White Paper on Health*. It is not limited to one single

[306] Ministry for Planning, Monitoring and Evaluation (Ministry for PME) *Final Impact Assessment (Phase 2): White Paper on National Health Insurance* (2017) 3.
[307] Ministry for PME (2017) 2.
[308] Preamble *NHI Bill* (2019) 2.
[309] Clause 1.1.3 *White Paper on the NHI* (2017) 3. Preamble *NHI Bill* (2019) 2.
[310] Clause 1.2.14 *White Paper on the NHI* (2017) 4.
[311] *White Paper on the NHI* (2017) 9. Mayosi, Lawn & Van Niekerk (2012) 2036.

document or policy but a combination of policies and country-specific circumstances that propels government to transform the health sector.

3.4. How will the National Health Insurance work?

3.4.1. Establishment of the National Health Insurance Fund

This analysis of how the NHI scheme will work is based on the White Paper on the NHI and the NHI Bill. The NHI Bill will establish a Fund. The Fund will be responsible for purchasing a comprehensive, uniform package of health services from health providers ranging from PHC through to specialised care.[312] The Fund will serve as a single purchaser of health services, where the Fund purchases health care services from accredited and certified health establishment that the Fund has contracted with.[313] The Fund will also be the only body paying health care providers for the health services that the health care providers deliver.[314] The Fund is ultimately responsible for taking reasonable measures to ensure the attainment of UHC.[315]

The focus under the NHI scheme is on PHC services,[316] with a wider range of care gradually being purchased by the Fund.[317] The details about the services in the so-called comprehensive package remain unclear, as a Board that has to determine what services the package consists of will be established.[318] Most health care will be free,[319] which includes doctors' visits and hospital stays.[320]

[312] Wayburne PA *Developing a Constitutional Law Paradigm for a National Health Insurance Scheme in South Africa* (unpublished PhD, University of the Witwatersrand, 2014) 3.
[313] Clause 2(*a*) and (*c*) *NHI Bill* (2019) 7.
[314] Clause 2(*a*) *NHI Bill* (2019) 7.
[315] Clause 10(1)(*a*) *NHI Bill* (2019) 11.
[316] See section 1.1 ch 1.
[317] Staff Writer 'How you will be paying for the NHI, and what happens to your medical aid - everything you need to know' (How you will be paying for the NHI) *BusinessTech* 8 August 2019 available at *https://businesstech.co.za/news/government/333817/how-you-will-be-paying-for-the-nhi-and-what-happens-to-your-medical-aid-everything-you-need-to-know/* (accessed 13 August 2019).
[318] Clause 25(5) *NHI Bill* (2019) 17.
[319] WHO submits that it is impossible for any country to provide all health interventions for free. WHO 'Universal Health Coverage' *WHO* 24 January 2019 available at *https://www.who.int/news-room/fact-sheets/detail/universal-health-coverage-uhc* (accessed 29 August 2019).
[320] Wasserman H 'Here's how the NHI will affect you- including new rules about seeing a specialist' *Business Insider SA* 12 August 2019 available at *https://www.businessinsider.co.za/nhi-health-medical-aid-2019-8* (accessed 13 August 2019).

Medical aid schemes, however, will be limited to providing complementary health care services.[321] There is still great uncertainty as to the fate of medical schemes, with the uncertainty of what the state's package of health services will consist of.[322]

The Fund will be located in the national sphere of government and will ultimately be accountable to the Minister, regarding the Fund's performance and functions.[323] The NHI Bill establishes a Board of the Fund (Board) that will be responsible for governing the Fund, however, this Board is accountable to the Minister.[324] Moreover, the Fund will have to perform its functions in accordance with health policies that the Minister has approved.[325] Furthermore, in terms of clause 10(4) of the NHI Bill, the Fund must support the Minister in the Minister's obligation to 'protect, promote, improve and maintain the health of the population'.

3.4.2. Registration for prospective National Health Insurance users

Prospective NHI users would have to be registered with the Fund at an accredited and contracted health facility or provider. An accredited and contracted PHC facility or a general practitioner (GP) will be the first point of contact for any health diagnosis or treatment.[326] The NHI Bill also sets out the requirements for registration.[327] Once registered, a strict referral system, starting at PHC level then moving to a more clinically intense level through a referral by the PHC provider or GP, must be adhered to for the Fund to reimburse NHI health care providers.[328] If the strict referral system is not adhered do, NHI registered users will bear the costs of care themselves. Whether medical aid schemes can cover an NHI user in such a scenario, remains unclear, since medical aid schemes

[321] Complementary healthcare services encompass services that will not be reimbursed by the NHI. Staff Writer 'Discovery on the NHI and future role of medical schemes' *BusinessTech* 13 August 2019 available at *https://businesstech.co.za/news/business/334381/discovery-on-the-nhi-and-future-role-of-medical-schemes/* (accessed 13 August 2019).
[322] Donnelly L 'NHI: The good, the bad, the ugly' *Mail & Guardian* 16 August 2019 19.
[323] Clause 10(1)(*l*) *NHI Bill* (2019) 11.
[324] Clause 12 *NHI Bill* (2019) 13.
[325] Clause 10(3) *NHI Bill* (2019) 12.
[326] Clause 1 *NHI Bill* (2019) 6.
[327] Clause 5 *NHI Bill* (2019) 8.
[328] Clause 1 *NHI Bill* (2019) 6.

will only be limited to complementary health services. Moreover, the type of health services that will fall within complementary health services remain uncertain, as the NHI Bill does not specify the services. Instead, the NHI Bill provides that in instances wherein care that does not form part of the comprehensive package of services that the Fund will purchase, will be categorised under complimentary health services.

3.4.3. Implementation of the National Health Insurance scheme

The NHI will be implemented over three major phases, with these phases being divided into sub-phases. Phase one was completed in 2017 which primarily focused on evaluating and improving the current public health system and setting up NHI pilot sites. Phase two is currently in progress which includes passing the NHI Bill which sets up the Fund and its constituent units.[329] The third phase is projected to take place from 2021/22 until 2026. The third phase will include the introduction of NHI-specific taxes and the ongoing strengthening of the public health system.[330] The NHI will be phased in over the next 7 years until its complete rollout in 2026.[331]

3.5. The proposed changes to the public health sector by the National Health Insurance Bill

The delivery of PHC services is at the heart of the NHI. Accessibility, which includes bringing health care services closest to the community, is paramount to UHC.[332] There has been much controversy around the NHI Bill, from the national treasury's concerns on the constitutionality of the NHI Bill to the Director-General of Health's saying that she had not seen the final draft of the NHI Bill or signed it off before it had been assigned to a cabinet sub-committee.[333] The analysis

[329] Phase 2 is mainly concerned with the establishment of the Fund and its components that will be created once the Bill is passed by both houses of Parliament. *NHI Bill* (2019) 47. The Bill has been tabled in the National Assembly of Parliament. Parliament's portfolio committee gave interested parties until 11 October 2019 to make submissions regarding the Bill. Kahn T 'Parliament calls for public submissions on NHI Bill' *BusinessLive* 2 September 2019 available at *https://www.businesslive.co.za/bd/national/health/2019-09-02-parliament-calls-for-public-submissions-on-nhi-bill/* (accessed 3 September 2019).
[330] Ministry for PME (2017) 5.
[331] Paton C 'Provinces ask for caution on national health insurance' *BusinessDay* 23 August 2019 2.
[332] *NHI Bill* (2019) 6. Clause IV Alma Ata Declaration (1978).
[333] Cullinan K 'Cabinet decision on NHI Bill expected next month' *IOL* 7 December 2018 available at *https://www.iol.co.za/news/politics/cabinet-decision-on-nhi-bill-expected-next-month-18417715* (accessed 12 July 2019).

below will include limited reference to the White Paper on Health, and will mainly focus on changes as proposed by the NHI Bill.

3.5.1. Changes to the national government's role in health services

The NHI proposes to make several changes to the health sector. The national government will effectively place all medical services under its control,[334] as the NHI essentially will lay the foundation for creating a health system under the sole control of the NDoH.[335]

3.5.1.1. National government's role regarding policymaking

Regarding the role of the national government in relation to policymaking and regulating the public health sector, the White Paper on the NHI and the subsequent NHI Bill do not provide any changes to this policymaking role. The Minister will also continue to be the steward of the national health system under the NHI scheme.

3.5.1.2. National government's role regarding monitoring of health services

The role of the national government regarding the overall monitoring of the public health system will not change significantly. The NDoH is currently responsible for monitoring provinces' provision of health services, and local government to a limited extent. However, due to the hierarchy present, national government oversees provinces and provinces oversee local government activities by monitoring and supporting local government.[336] Under the NHI, the national government's monitoring role will increase slightly by having a more direct monitory role at local government level, through the establishment of the district health management office (DHMO) that will be directly accountable to the Minister.[337]

[334] Joubert JJ 'NHI South Africa: Plan to fight state takeover of doctors expected today' *The South African* 13 August 2019 available at *https://www.thesouthafrican.com/opinion/nhi-south-africa-problems-explained/* (accessed 13 August 2019).
[335] Cullinan (2018) 2.
[336] Steytler N & De Visser J *Local Government Law of South Africa* (2014) 15-7.
[337] *NHI Bill* (2019) 49.

3.5.1.3. National government's role regarding health-related procurement

Since the NDoH took over the procurement of antiretrovirals (ARVs) and other medicine from the national treasury, its role in procurement will increase as the NHI Bill introduces an office of health products procurement, to include the procurement of other health-related products such as medical equipment. In terms of clause 38(1) of the NHI Bill, the Board that will be established to function as the 'accounting authority' of the Fund must,[338] in consultation with the Minister, establish the office of health products procurement, which will be responsible for the procurement of health-related products. The NHI Bill provides that the procurement of health-related products will include but will not be limited to medicines, medical devices and equipment.[339] This office will be located within the Fund that is under the governance of the Minister. However, the NHI Bill is not clear as to how this office will be managed and governed;[340] it only outlines a vague role of supporting the Benefits Advisory Committee in developing and maintaining a Formulary.[341] The Formulary will contain an essential medicine list and an essential equipment list, from which health-related products should be purchased and that the office of health products procurement will be under the governance of the Minister.[342]

3.5.1.4. National government's role regarding public hospitals

A major proposed change and one of the most controversial parts of the NHI, is the change in the governance of central hospitals. According to the White Paper on the NHI, reorganising the health system includes the governance of central hospitals moving them from provinces to the national sphere, which is discussed below.[343]

[338] According to clause 15 of the *NHI Bill*, the Board will be accountable to the Minister and have the power to advise the Minister on any matter that concerns the management and administration of the Fund, the pricing of health care services that the Fund should purchase and the budget of the Fund, among others.
[339] Clause 38(2) *NHI Bill* (2019) 19.
[340] Donnelly (2019) 19.
[341] Clause 38(4) *NHI Bill* (2019) 21.
[342] Clause 38(4) *NHI Bill* (2019) 21.
[343] *White Paper on NHI* (2017) 34.

3.5.2. Changes to provincial governments' role regarding health services

The reorganisation of the entire health system under the proposed NHI is argued to be the most ambitious attempt by the national government.[344] Moreover, most of the changes in public health seem to be directed at provinces or the least at the expense of provinces.

First, a striking change is the definition of health services under the NHI Bill compared to the NHA.[345] The NHA provides the legal framework for health service delivery in practice and comprises health care services including reproductive health services, child health care services, emergency health services and municipal health services.[346] Under the NHI Bill, the definition of health services is broadened to include 'provincial health services'.[347] This implies that provinces will still be providing health services. It is also implied from the definition that national government will start to play a bigger role in the actual delivery of health services. In addition, the NHI Bill limits the so-called 'provincial health services' to 'where applicable'.[348] Evidently, provinces will no longer be the main drivers of health care services as the national government will be in the forefront in delivering health care services through the NHI scheme. Moreover, the NHI Bill provides that the NDoH can delegate the function to provide health services to provinces that the NHI Bill describes as being 'management agents'.[349] This supports the contention that provinces will no longer be the main drivers of health care services as they currently are, if the NDoH has power to 'delegate' a function that provinces already perform, in practice.

3.5.2.1. Provincial government's role regarding public hospitals

Provinces will lose control of the so-called central hospitals as these hospitals will no longer be managed by provinces, but by the NDoH.[350] This is evident as the NHI Bill proposes to move

[344] Paton C 'Provinces ask for caution on national health insurance' *BusinessDay* 23 August 2019 2.
[345] Act 61 of 2003.
[346] Section 1 Act 61 of 2003.
[347] *NHI Bill* (2019) 6.
[348] *NHI Bill* (2019) 6.
[349] Clause 32(2)(*a*) *NHI Bill* (2019) 19.
[350] *White Paper on the NHI* (2017) 34.

central hospitals to the national sphere. In the Gauteng province, the Premier, has called for the NDoH to take over four central hospitals (of the total of ten across South Africa) located in the province, as the Premier argues that the provincial government is 'chronically underfunded' for them to perform their role.[351] Central hospitals are funded through conditional grants of which the funds have steadily been decreasing and places more pressure on provinces' health budget.[352] Additionally, the NHI Bill gives the NDoH discretionary powers to nationalise other categories of hospitals such as tertiary and regional hospitals.[353]

3.5.2.2. Provincial government's role regarding primary health care services and the district health system

The national government aims to re-engineer PHC services, which is about changing the manner in which PHC services are currently delivered and financed.[354] PHC services will be provided through four categories under the NHI scheme. These categories include Municipal Ward-based PHC Outreach Teams (consisting of community health workers who are linked to a PHC facility such as a clinic),[355] school health-based programmes,[356] district clinical specialist teams and contracted private practitioners.[357] This re-engineering will be done by emphasising the role of community health workers by doing house calls and focusing on balancing health prevention (through preventative mechanisms such as health education and immunisations) and health promotion with hospital curative services.[358]

[351] Kahn T 'Gauteng wants health department to finance its four central hospitals' *BusinessDay* 28 August 2019 2.
[352] Kahn (2019) 2.
[353] Clause 32(2)(*c*) *NHI Bill* (2019) 19.
[354] Mayosi, Lawn & Van Niekerk (2012) 2033.
[355] *White Paper on the NHI* (2017) 29-30.
[356] *White Paper on the NHI* (2017) 30.
[357] *White Paper on the NHI* (2017) 30.
[358] Mayosi, Lawn & Van Niekerk (2012) 2033-6.

The DHMO will be established and will be the delivery platform for PHC services, which is a change from the current district health system (DHS) which is under provinces' control.[359] The DHMOs will be accountable to the national sphere. However, according to the NHI Bill, appropriate governance structures will be established at district level.[360] This is a tune that has been sung before. Since provinces are responsible for the DHS and refused to decentralise authority to districts, it is hard to believe that national government will not follow in the same footsteps as provinces.[361] The national government already seems to be centralising health services through the proposed NHI, as opposed to decentralising it.

Moreover, the NHI Bill provides that PHC providers will be contracted and remunerated by the Contracting Unit for PHC (CUPs) that will be established by the DHMO. Therefore, it can be implied that the provinces will not be remunerating health professionals in the public hospitals and clinics that provinces own.[362] It appears that provincial health departments will no longer be paying the salaries of their health personnel and employees as the Fund will be contracting directly with public hospitals and the CUPs.

Moreover, the District Health Information System (DHIS) currently in place will be replaced by a National Health Information System.[363] In addition, the NHI Bill proposes that complaints by any NHI health care user or provider, should be addressed to the Fund. Currently provinces deal with complaints and have put in place complaints mechanisms. This will change as complaints will

[359] *NHI Bill* (2019) 48.
[360] *NHI Bill* (2019) 49.
[361] Choonara S *A Comparative Analysis of Financial Management Practices at a District Level in South Africa* (unpublished PhD, University of the Witwatersrand, 2017) 33.
[362] Clause 41(3)(*a*) *NHI Bill* (2019) 23.
[363] DHIS provides information of all PHC facilities and district hospitals. Improved ways for the medical records of the public sector should be put in place, as records go missing in some of these PHC facilities and public hospitals. Additionally, the record keeping of PHC facilities and public hospitals are outdated. Mayosi, Lawn & Van Niekerk (2012) 2040.

have to be sent to the Fund and an investigating unit will be established to investigate such complaints.[364]

3.5.2.3. Provincial government's role regarding referral networks

Provinces are currently responsible for creating referral networks. The NHI, once implemented, will put in place strict referral pathways that should be followed, since the current referral pathways are not stringently enforced. Health care users who usually go to specialists before going to PHC facilities will be restricted from doing this once registered under the NHI. Under the NHI, health care users who do not strictly adhere to the referral pathways, will not be covered by the Fund for the care or treatment that they received by bypassing the referral pathways.

3.5.2.4. Provincial government's role regarding emergency medical services

Provinces play a major role in EMS, as these services largely incorporate ambulance services.[365] Ambulatory services are an exclusive competence of provinces.[366] Provincial health departments are currently responsible for the provision and co-ordination of EMS.[367] Currently, the NHA provides the Minister with discretionary powers to make regulations regarding EMS.[368] Under the NHI, the national government will play a role in public EMS. The NHI Bill does not provide ample detail regarding the extent of the role that the national government will play in EMS. The NHI Bill, does however, propose that the Fund will purchase EMS from both private and public providers.[369] EMS incorporates ambulance services too. The NDoH will therefore intrude into the exclusive domain of an already deteriorating sphere.

The White Paper on the NHI provides that the Fund will only contract health providers that are accredited by the newly established Office of Health Standard Compliance (OHSC). The policy

[364] Clause 42 *NHI Bill* (2019) 24.
[365] Van Huyssteen (2017) 15. See section 2.4.2 ch 2.
[366] Schedule 5A Constitution.
[367] Section 25(20)(*m*) Act 61 of 2003.
[368] Section 91(1)(*m*) Act 61 of 2003.
[369] Clause 35(4)(*a*) *NHI Bill* (2019) 20.

does not mention how public health care providers who have not been accredited by the OHSC will be funded. It can be deduced that unaccredited public health care providers will probably have to rely on conditional grants from the national treasury to provide health services.

3.5.3. Changes regarding local government's role in relation to health services

Media coverage of the NHI and an analysis of the NHI Bill itself does not seem to indicate that many changes to the current role of local government regarding 'municipal health services' will take place. The NHI Bill is mostly concerned with personal health care as opposed to environmental aspects of health that local government is responsible for.

However, since metropolitan municipalities continue to deliver PHC services, these municipalities are likely to be affected by the changes to the manner in which PHC will be delivered. The NHI Bill also provides for the establishment of CUPs at local level, who will assist the Fund in identifying the health needs of the communities they are in.[370] These CUPs will provide and manage the provision of PHC services,[371] which detracts from metropolitan municipalities' role in managing the provision of PHC services that metropolitan municipalities currently deliver.

Moreover, the NHI Bill, gives the Minister discretionary power to establish the DHMOs to provide non-personal health care services, that is, environmental health.[372] This would mean that local government's role in relation to environmental health services could deteriorate in the event that the Minister uses this discretionary power.

3.6. How will the NHI be funded?

Currently, the controversial NHI Bill is being tabled in Parliament and mainly sets out the architecture for the Fund and not much else. The NHI Bill sets out different revenue sources for the Fund. The proposed funding for the NHI and its components will come from direct and indirect

[370] Clause 37(2)(*a*) *NHI Bill* (2019) 20.
[371] Clause 37(1)(*a*) *NHI Bill* (2019) 20.
[372] Clause 32(2)(*c*) *NHI Bill* (2019) 19.

taxes.[373] The transfer of the health portion of the provincial equitable share (PES) and health-related grants from provinces to the Fund will take place. General taxes including medical scheme tax credits will be reallocated to the Fund, payroll tax on employees and employers and a surcharge on personal income tax.[374] These taxes will be levied at a later stage of the NHI implementation.[375] The NDoH, does however, contend that the main sources of funding for the NHI will come from the transfer of the health portion of the PES and health-related grants.[376] Other tax sources will gradually be introduced, such as value added tax (VAT).[377]

The health portion of the PES and health-related grants currently transferred to provinces to enable provinces to deliver health services will be redirected to the Fund. The national government submits that improving the use of public funds through redirecting the PES and conditional grants to the Fund is for the enhancement of transparency in performance and to have appropriate governing mechanisms in place.[378]

3.7. Major criticisms on the National Health Insurance

3.7.1. National government is not always the best sphere to deliver services

Despite the national government contending that the NHI scheme will not be a state-owned entity (SOE), everything about the NHI and its components suggests the opposite. The Fund will be under the helm of one person, the Minister. To substantiate this assertion, the budget allocation under the NHI will be looked at as an example. District management will not have inputs in budget

[373] Clause 49(2)(*a*)(ii) *NHI Bill* (2019) 25. The taxes will be introduced through a money bill that the Minister of Finance will mark for usage by the NHI Fund. Staff Writer 'How much more you would have to be taxed to make NHI "work'' *BusinessTech* 12 August 2019 available at *https://businesstech.co.za/news/finance/334169/how-much-more-you-would-have-to-be-taxed-to-make-nhi-work/* (accessed 13 August 2019).
[374] Clause 49(2)(*a*)(ii) *NHI Bill* (2019) 25.
[375] Staff Writer 'How you will pay for the NHI' (2019) 1.
[376] Staff Writer 'How you will pay for the NHI' (2019) 1.
[377] Brandt K 'SA's NHI bill not properly thought through, says doctors' forum' *Eyewitness News* 13 August 2019 available at *https://ewn.co.za/2019/08/13/sa-s-nhi-bill-not-properly-thought-through-says-doctors-forum* (accessed 13 August 2019).
[378] Ministry for PME (2017) 7-8.

allocations as the Fund, in consultation with the Minister, will determine the price regimen and payment methods for health providers who the Fund will reimburse.[379] In addition, the current problems present in the public health sector regarding the lack of input by the districts in budget allocations would be exacerbated under an NHI,[380] where the Fund determines whether health care providers have complied with the contractual conditions or standards for reimbursements by the Fund.[381] Additionally, the RDP envisages PHC services to be delivered through a District Health Authority (DHA), as does the *White Paper on Health*. In practice, provinces have already failed in decentralising power to districts to deliver these services. The NHI purports to do the same. Even though the NHI represents this supposed beacon of decentralisation, essentially the DHMO will be a national component, giving the NDoH more power in its hands as these offices will be accountable to the Minister. Additionally, it is a regression as South Africa has come a long way to decentralise the public health sector.[382]

The NHI could possibly be another vehicle for corruption, like other SOEs, as the national bureaucracy does not have a blemish-free record when it comes to corruption.[383] Corruption will not only stifle economic growth and development, it also has a negative effect on health service delivery, its affordability and health care spending.[384] The NHI can do more harm than good and follow in the footsteps of current SOEs such as Eskom and South African Airways (SAA). Eskom and SAA are failing in management and delivery and with the NHI purported to be larger than these enterprises, it could be disastrous for South Africa. The Minister of Health, however,

[379] Clause 41(1) *NHI Bill* (2019) 23.
[380] Choonara (2017) 60.
[381] Clause 41 *NHI Bill* (2019) 24.
[382] Choonara (2017) 33.
[383] Staff Writer 'Why the NHI is headed for disaster' *BusinessTech* 26 July 2019 available at *https://businesstech.co.za/news/government/331609/why-the-nhi-is-headed-for-diaster/* (accessed on 13 August 2019).
[384] Brauns (2016) 144.

contends that the NHI will not follow in the steps of Eskom.[385] Only time will tell once the NHI scheme is implemented.

Moreover, the national government did not provide the public with progress information on the NHI pilot sites, until the Democratic Alliance (DA) made the public aware of the poor state of the NHI pilot sites. The national government confirmed this leaked information to be true.[386] The holding back of this information by the NDoH already signals trouble for the NDoH regarding accountability and transparency.

Wayburne asserts that having a national public administration system is likely to reduce wasteful expenditure because the public system will be in a better position to make more efficient and effective allocation decisions.[387] This, however, is not always the case. Although the public health sector is not necessarily profit driven like the private sector, corruption in the public sector is a major issue. Corruption hampers service delivery and leaves the public at a disadvantage. Health care delivery would then become inefficient and allocations would not be sufficient to deliver these services to those who need it most.

It is argued that despite the NHI being a vehicle for the supposed reinforcement of decentralised health service delivery by building up the CUPs to be the point through which PHC services are delivered, the NHI could likely reinforce the challenges faced under apartheid. These challenges include having a top-down management culture that the NDoH is planning once the NHI is fully implemented.[388] This in effect could stifle health service delivery as the national government is too far removed from the communities to be held accountable. Moreover, the NHI Bill does not

[385] The Minister contends that the NHI will be implemented in an affordable manner and will not pose the same risks as Eskom. Kahn T 'NHI fund will not be another Eskom, says health minister' *BusinessDay* 26 August 2019 available at *https://www.businesslive.co.za/bd/national/health/2019-08-26-nhi-fund-will-not-be-another-eskom-says-health-minister/* (accessed on 26 August 2019).
[386] Joubert (2019) 1.
[387] Wayburne (2014) 33.
[388] Choonara (2017) 49.

provide any details on how the public health system will undergo the transition to operate effectively under an NHI.[389]

3.7.2. Financial affordability

Despite South Africa's current economic state,[390] the Minister of Health is headstrong about the NHI's implementation.[391] The NHI will cost a massive R256 billion per year according to 2010 estimations.[392] Economists however contend that this is an inaccurate estimation and that the NHI will be more expensive.[393] The Minister of Health contends that those estimations are guesstimates and that proper estimations will be pursued in due course.[394] In addition, the NHI Bill does not provide any details as to how much the NHI will cost each year.[395] The uncertainty this creates could hamper service delivery in the event that South Africa is not able to sustain such a scheme.

In addition, taxes will increase which will place a huge burden on a society that is already overburdened with taxes. Increasing taxes could be counter-productive as it could negatively affect the very people the NHI aims to cater for, through increases in tax such as VAT.

[389] Section27 'Annual review' available at *https://www.section27.org.za/wp-content/uploads/2019/07/SECTION27-Annual-Review_2018_Digital.pdf* (accessed 17 October 2019).
[390] South Africa's economy has been in a crisis and is growing slowly. Khumalo K 'Higher taxes on the cards as government scrambles to implement NHI' *IOL* 12 August 2019 available at *https://www.iol.co.za/business-report/economy/higher-taxes-on-the-cards-as-government-scrambles-to-implement-nhi-30673151* (accessed 12 August 2019). In addition, the unemployment rate is the highest it has ever been in the country. There has been a decline in South Africa's tax base. Sokutu B 'NHI plan would have disastrous consequences' *The Citizen* 23 June 2018 available at *https://citizen.co.za/news/south-africa/1961513/nhi-plan-would-have-disastrous-consequences-free-market-foundation/* (accessed 12 August 2019).
[391] Brandt (2019) 1.
[392] *White Paper on the NHI* (2017) 40.
[393] Gonzales LL 'Analysis: The national health insurance – what it means and the fights we can expect' *News24* 8 August 2019 available at *https://www.news24.com/Analysis/analysis-the-national-health-insurance-what-it-means-and-the-fights-we-can-expect-20190808* (accessed 12 August 2019).
[394] Staff Writer 'How you will pay for the NHI' (2019) 1.
[395] Staff Writer 'How you will pay for the NHI' (2019) 1.

3.7.3. Decrease of provincial government's role

These changes could be catastrophic and hinder health service delivery in the near future, as the national government does not have the best record with service delivery, in general.[396] In practice, the NDoH generally limits itself to policymaking in concurrent functional areas. This means that the NDoH is likely to lack the skills and expertise in health service delivery.[397] Many groups, organisations and political opposition to the ANC are contending that the NHI will lead to health services being nationalised, as the NHI Bill envisages more centralisation.[398]

With national government's role seemingly increasing and provincial government's role regarding the actual delivery of health services decreasing, an important question would be whether the stripping of province's powers can pass constitutional muster?

3.8. Conclusion

This chapter sets out the evolution of the NHI and how the NHI will work in the event it is fully implemented. The NHI derives its mandate, namely through section 27 of the Constitution. The several changes that the NHI scheme will make to the current public health services and the manner in which these health services are currently delivered was dealt with. At national level, the NDoH will be playing a bigger role in the actual delivery of health services as central hospitals will be administered and run by the NDoH. Additionally, health funding will be transferred to the nationally-run Fund. At provincial level, there are several changes, mainly that provinces' role as the main deliverers of health care services will decrease. This is argued because provinces will first, lose control over central hospitals. Secondly, provinces will no longer be monitoring the DHS, as a new system the DHMO will be created that monitors PHC delivery. Thirdly, provinces

[396] In fact, service delivery at all three levels of government has problems or is inadequate. See Roodt M 'NHI not a panacea for the nation's ills' *IOL* 1 September 2018 available at *https://www.iol.co.za/news/opinion/nhi-not-a-panacea-for-the-nations-ills-16842413* (accessed 12 July 2019).
[397] De Visser & May (2015) 158.
[398] Phakathi B 'DA raises legality challenge to health reforms' *BusinessDay* 14 August 2019 6.

will lose a third of their funds (the health portion makes up one third of provinces' expenditure) because the health portion of the PES and health-related grants will be redirected to the Fund. These proposed changes are likely to have an impact on provinces that are responsible for the actual delivery of health care services by reducing provinces' role in this regard. Provinces will probably have to get a conditional grant if they want to do health experiments or introduce and implement their own health policies. At local level, metropolitan municipalities could be affected as the DHMO will be responsible for co-ordinating and facilitating the provision of PHC services, which is directly accountable to the Minister. Moreover, the NHI Bill does not provide ample detail to changes that are likely taking place to environmental health services, which local government is largely responsible for. Aside from the discretionary powers that the Minister has in terms of placing the management of non-personal health services under the DHMO, there are not many details in the NHI Bill about environmental health services.

Moreover, consolidating all the public and private health funds to a single national entity essentially means nationalising health services and a reduction of subnational government's role in an important socio-economic function.[399] The impact and constitutionality of the proposed changes on provinces and local government will be discussed in more detail in chapter four.

[399] Phakathi (2019) 6.

CHAPTER 4: THE CONSTITUTIONALITY OF THE NATIONAL HEALTH INSURANCE BILL

4.1. Introduction

The changes proposed by the NHI Bill, discussed in the previous chapter, will result in the national government becoming the single authority over health services, by placing health service delivery under its control. [400] This will impact dramatically on the provincial role in providing health services, as described in chapter two. Upon the release of the NHI Bill, the Democratic Alliance (DA) contended that the NHI Bill is likely to be unconstitutional and asked Parliament to seek legal advice.[401] The DA argues that the NHI Bill will intrude on provinces' constitutional powers to provide health care.[402] This chapter therefore focuses on the constitutionality of the proposed changes. First, the constitutionality of the proposed change in national government's role in the exercise of its concurrent power over health services is discussed. Secondly, conflicts between national legislation and provincial legislation will be discussed, specifically whether the NHI Bill could trump provincial laws. Thirdly, national government's power in relation to exclusive provincial powers is examined. Fourthly, the constitutionality of changes to local government's role will be discussed.

4.2. The constitutionality of the change in national government's role under a National Health Insurance in exercising its concurrent power over 'health services'

Currently, the National Department of Health (NDoH) has a limited role in the actual delivery of health services, with its role largely confined to policymaking and monitoring subnational government's provision of these services.[403] The NDoH's role regarding health services will

[400] Phakathi B 'DA raises legality challenge to health reforms' *BusinessDay* 14 August 2019 6.
[401] Kahn T 'Parliament calls for public submissions on NHI Bill' *BusinessLive* 2 September 2019 available at *https://www.businesslive.co.za/bd/national/health/2019-09-02-parliament-calls-for-public-submissions-on-nhi-bill/* (accessed 3 September 2019) 1.
[402] Phakathi (2019) 6.
[403] Sections 3(1) & 4 National Health Act 61 of 2003.

increase if the NHI scheme is implemented if the NDoH becomes involved in the actual delivery of health services, by placing the delivery of specialised health care and primary health care (PHC) under its control.[404] The constitutionality of the change in the administration of central hospitals will be discussed first, followed by the constitutionality of the takeover of PHC services from provincial health departments.

4.2.1. Administration of central hospitals

Provincial governments currently own so-called 'central' hospitals. The NDoH will increase the NDoH's role by taking over the administration of central hospitals and essentially the highly specialised care offered by these hospitals.[405] The pertinent issue is whether the NDoH is constitutionally permitted to take over the administration of provincially-owned hospitals.

According to section 44(1)(*a*)(ii) of the Constitution, Parliament can legislate on any matter in schedule 4. Schedule 4A confers concurrent powers on both national and provincial spheres of government to legislate on any matter present in that schedule. National and provincial governments have equal law-making powers regarding concurrent competences. The Constitutional Court (CC) has affirmed that both national and provincial governments are free to make laws in areas of concurrency.[406]

Therefore, nothing bars the national government from exercising its power in schedule 4A matters by centralising functions in this schedule because health services is a concurrent competence. For example, welfare services are a schedule 4A competence. In 2004, the administration of social grant disbursements was centralised to a national agency, the South African Social Security

[404] See section 3.5 ch 3.
[405] Clause 7(2)(*f*) Ministry for Health *National Health Insurance Bill* (*NHI Bill*) (published in *GG* 42598 of 26 July 2019) 10. See section 2.4.2 ch 2 for less specialised services.
[406] *Ex Parte Speaker of the National Assembly in re Dispute Concerning the Constitutionality of Certain Provisions of the National Education Policy Bill No 83 of 1995* (*National Education* Bill case) 1996 (4) BCLR 518 (CC), para 12.

Agency (SASSA), which were previously administered by provinces.[407] Due to the high levels of corruption in handling these grant disbursements at provincial level, the national government centralised the administration and payment of social grants.[408] Provinces, however, are still required to implement social grant policies and monitor the service delivery of these disbursements. Unlike the proposed move of central hospitals to the national sphere under the NHI, in relation to SASSA, provinces retained their infrastructure of service points of grant disbursements.[409]

Despite the national government having the power to perform functions listed in schedule 4A, such as health services, at issue is how such powers are exercised. The exercise of these powers should be done in accordance with the principles of co-operative government.[410] Section 40 of the Constitution recognises all three spheres of government as being distinct from each other, while simultaneously being interdependent and interrelated to each other.[411] In terms of section 40 of the Constitution, the three spheres are compelled to observe and adhere to the principles of co-operative government. Section 41 of the Constitution provides for the principles for co-operative governance and intergovernmental relations. One of these principles requires all spheres of government to 'respect the constitutional status, powers and functions of the other spheres'.[412] Moreover, section 41(1)(*g*) of the Constitution provides that other spheres should not encroach on the 'geographical, functional or institutional integrity' of government in other spheres in the

[407] Chelechele TI *A Critical Analysis of the Implementation of the Social Assistance Grant Policies in the North West Province of South Africa* (unpublished Masters in Public Administration, University of Pretoria, 2010) 1.
[408] Powell D 'Intergovernmental relations in South Africa' in Poirier J, Saunders C & Kincaid J (eds) *Intergovernmental Relations in Federal Countries* (2015) 321.
[409] Chelechele (2010) 109.
[410] *The Premier of the Province of the Western Cape v The President of the Republic of South Africa* (*WC Premier* case) 1999 (4) BCLR 382 (CC), para 57.
[411] Distinctiveness refers to a provision having been made for elected governments at all three levels. Interdependence and interrelatedness comes from the founding provisions that South Africa is 'one sovereign and democratic' state. *Premier of the WC* case, para 50.
[412] Section 41(1)(*e*) Constitution.

exercise of their respective powers. This principle is aimed at protecting the autonomy of provinces (and other spheres).[413]

In the *Premier of the Western Cape v The President of the Republic of South Africa* (*WC Premier* case),[414] the Constitutional Court (CC) dealt with the Public Service Laws Amendment Act (PSA)[415] which sought to reorganise the structure of the public service in terms of section 197 of the Constitution which provides that the public service must be structured in terms of national legislation. Provinces are, however, given powers to employ their own staff.[416] The amendment, however significantly restructured the public administration in provinces. The issue in the case, was whether Parliament could prescribe how provincial administrations were to be structured.[417] The Western Cape government therefore, contended that the amendments infringed on their executive power to determine the structure of their provincial administrations as this detracts from the legitimate autonomy of provinces, and should therefore be declared unconstitutional.[418] The CC noted that legitimate provincial autonomy means that provinces should have regard for the national government's framework and must exercise their power within the prescribed framework.[419] The framework should not constrain the exercise of provincial powers in a way that prevents provinces from effectively exercising their powers vested by the Constitution.[420] The CC reasoned that if the structure and aspects of public service would reside solely in the national government, personnel would be employed by and answerable to the national functionaries, that would be a material detraction from provinces' autonomy and would be unconstitutional.[421] The CC found that the amendment of the PSA, however, struck a compromise between the framework

[413] Brand D 'The South African Constitution: Three crucial issues for future development' (1998) 9(2) *Stellenbosch Law Review* 185.
[414] 1999 (4) BCLR 382 (CC).
[415] Act 86 of 1998.
[416] Section 197(4) Constitution.
[417] *WC Premier* case, para 7.
[418] *WC Premier* case, para 7.
[419] *WC Premier* case, para 32-6.
[420] *WC Premier* case, para 36.
[421] *WC Premier* case, para 46.

of the public service being set by national legislation and provinces retaining power to employ their own personnel.[422] For this reason, the CC held that the main attack on the constitutionality of the new scheme proposed by the PSA must fail.[423]

Additionally, one of the amendments provided that the establishment or abolition of provincial departments is dependent on the President's approval.[424] Another issue before the CC was whether this new scheme infringed on provinces' executive powers by encroaching on provinces 'geographical, functional or institutional integrity' in terms of section 41(1)(*g*) of the Constitution. The CC stated that section 41(1)(*g*) is concerned with the manner in which power is exercised not whether the power exists or not.[425] The CC noted that although it is unclear in which circumstances section 41(1)(*g*) can be invoked, the purpose of this provision is to prevent one sphere from using its power in a manner that undermines another sphere and prevents them from functioning effectively.[426] The CC further stated that the functional and institutional integrity must be determined with due regard for the constitutional order; powers and functions under the Constitution; as well as the countervailing powers of the other spheres.[427] The power of the national government, therefore has to be exercised carefully such that it does not encroach on provinces' ability to carry out provincial functions that have been entrusted to them by the Constitution.[428] Moreover, the CC reasoned that to protect the limited autonomy of provinces within the larger framework as prescribed by the Constitution, provinces should have the ability to employ their own personnel in provincial administration.[429] The CC further held that section 41(1)(*g*) of the Constitution would be infringed if the Premier had no say in the establishment of departments.[430]

[422] *WC Premier* case, para 46.
[423] *WC Premier* case, para 48.
[424] *WC Premier* case, para 77.
[425] *WC Premier* case, para 57.
[426] *WC Premier* case, para 58.
[427] *WC Premier* case, para 58.
[428] *WC Premier* case, para 60.
[429] *WC Premier* case, para 72.
[430] *WC Premier* case, para 82.

The CC's finding was that the amendment should not be construed as giving the President such power, instead the amendment recognised that the President cannot be obliged to amend schedule 2 that deals with provincial departments if it would be unconstitutional or unlawful for the President to do so.[431] The CC held that the Premier still retained the power to establish or abolish provincial departments but that such power is limited only to the extent that a request has to be directed to the President.[432] The CC held that the amendment does not infringe section 41(1)(*g*) of the Constitution, as the executive power to structure the public service is vested in the national government and the Premier still retains the power to establish or abolish the provincial department with a slight limitation upon such power as mentioned above.[433]

The *WC Premier* case is an important judgment for the paper, as it establishes the principle that in areas of concurrency (or exclusive) the legislative powers of the national government should be exercised in accordance with the principles of intergovernmental relations by the national government not encroaching on provinces' 'geographical, functional or institutional integrity'.[434] If there is such encroachment, the national law may be unconstitutional and thus invalid. Additionally, this judgment will help evaluate whether the taking over of the administration of central hospitals could pass constitutional muster, as there are many similarities between the case and the proposed changes of the NHI Bill. First, both the case and the proposed changes to the health sector deal with the reorganisation of an aspect of provincial administration. In health services, it concerns essentially the reorganisation of the administration of central hospitals by transferring the administration of these hospitals to the NDoH. Secondly, the CC's interpretation of when section 41(1)(*g*) of the Constitution will be infringed is important. Moreover, the constitutionality based on such an infringement is relevant to this paper as it is argued that the

[431] *WC Premier* case, para 77.
[432] *WC Premier* case, para 80.
[433] *WC Premier* case, para 82.
[434] *WC Premier* case, paras 56 & 65.

reduction of provinces role in relation to central hospitals could potentially be unconstitutional based on section 41(1)(*g*) of the Constitution, as this provision protects the functionality of provinces, amongst other things. If an encroachment is such that it prevents provinces' from using their powers effectively, it may be unconstitutional in terms of section 41(1)(*g*) of the Constitution.[435]

The NHI Bill provides that the Minister must designate central hospitals as competences of the national sphere, through regulations.[436] There is no doubt that the nationalisation of the administration of central hospitals imposes on provinces' ability to run these hospitals. The issue, however, is whether this imposition is constitutional. With health services being a concurrent function, the national government can exercise its powers over health services.[437] However, such power should be exercised by respecting provinces' concurrent power over health services. This would include provinces administering their own hospitals.[438] According to the CC in the *WC Premier* case, section 41(1)(*g*) of the Constitution protects provinces' autonomy and can be used to defeat the lawful exercise of the national government's concurrent power regarding health services, where the exercise of such power would undermine provinces' functionality in health services.[439] The national government is taking over provincially-owned hospitals, not merely building its own hospitals, to increase its role in health service delivery. It is argued that taking over of provincial hospitals encroaches upon provinces' functional integrity. Provinces will no longer run these hospitals and will no longer be able to perform the functions that are inherent with running these hospitals, such as employing hospital personnel or procuring health-related products, since these inherent functions will be nationalised together with the nationalisation of the provincial hospitals.[440] The CC has held that if provinces are not allowed to employ their own

[435] *WC Premier* case, para 58.
[436] Clause 7(2)(*f*)(i) *NHI Bill* (2019) 10.
[437] See section 2.2.2 ch 2.
[438] Sections 125(2) & (3) Constitution.
[439] *WC Premier* case, para 58.
[440] See sections 2.3 and 2.4 ch 2.

personnel, such structural changes would be unconstitutional because such structural changes materially detract from provinces' ability to function effectively.

The NHI Bill makes no mention, however, of whether the hospital property of provinces will be taken aside from the explicit mention that the 'administration, management, budgeting and governance' of central hospitals will be nationalised.[441] The NHI Bill does, however, provide that management of central hospitals will be semi-autonomous and the competence of the national sphere. Certain decision-making including minor infrastructure of central hospitals will be delegated by the national government.[442] The NHI Bill does not provide to whom certain decision-making will be delegated to. Additionally, the NHI does not provide clarity as to what 'minor infrastructure' includes in relation to these hospitals.

Therefore, with the proposed nationalisation of central hospitals under the NHI Bill,[443] and with much uncertainty as to the future role of provinces in health services, it would be interesting to know whether provinces have a constitutional right to property and if so, can their property be expropriated and under what circumstances. There is a lot of literature on private property in relation to natural persons and private entities or between such private property and the state,[444] but hardly any literature on property relations within a state, and between different spheres of government. There is some literature on a state's right to property. Such literature, however, is with regard to international law particularly the general prohibition of state(s) interfering with another state's property, where the national government operates as the state under international law.[445]

[441] Clause 7(2)(*f*)(ii) *NHI Bill* (2019) 10.
[442] Clause 7(2)(*f*)(iii) *NHI Bill* (2019) 10.
[443] Serfontein J 'State takeover of academic hospitals is not the answer' *BusinessDay* 12 July 2019 9.
[444] Allen T 'Property as a fundamental right in India, Europe and South Africa' (2007) 15(2) *Asia Pacific Law Review*.
[445] Tzeng P 'The state's right to property under international law' (2016) 125(6) *Yale Law Journal* 1810.

According to section 8(2) of the Constitution, the Bill of Rights applies to juristic persons as well as natural persons, however only to the extent applicable, taking into consideration the nature of the right. Provinces are juristic entities, therefore property rights would be applicable to them as owners of such hospitals. Moreover, according to section 8(1) of the Constitution, the Bill of Rights binds all organs of state. According to section 239 of the Constitution, an organ of state includes any 'administration in the…provincial sphere of government…' which would include provincial health departments. Additionally, according to schedule 6 of the Constitution,[446] 'on production of a certificate of immovable property by a competent authority that immovable property owned by the state is vested in that particular government… a registrar must register such property in the name of that government'. This is indicative that provinces could have a right to property where such immovable property vests in the provincial sphere. Therefore, provincial health departments could be entitled to have their property rights protected under section 25 of the Constitution and not have their property expropriated arbitrarily. In light of the above, it can be argued therefore that the Bill of Rights could apply to protect the property owned by different spheres of government.

Therefore, in taking over provincial hospitals, the national government is no longer exercising its power concurrently, but preventing provinces from functioning in health services. This undermines provinces' functional integrity that is protected in section 41(1)(*g*) of the Constitution and therefore, such change would potentially be unconstitutional. For the abovementioned reasons, the NHI Bill could potentially be unconstitutional.

With health services being a concurrent competence, provinces could pass their own legislation in conflict with what national government legislates on. In such an event, at issue would be whether

[446] Section 28(1).

the national law trumps the provincial law. Such a scenario will be dealt with under provincial powers.

Moreover, if the nationalisation of 'central' hospitals are due to provinces' failure to run these hospitals, national government could have opted to intervene in terms of section 100 of the Constitution, instead of initiating the NHI Bill. Section 100 of the Constitution is designed for administrative interventions. These interventions are temporary to correct maladministration in a province. The temporary assumption of the administration of central hospitals could therefore be justified under the Constitution, since national government bears the overall responsibility of ensuring that all the other spheres carry out their constitutional obligations.[447] Section 100 of the Constitution can be invoked where a province fails to comply with their constitutional obligation or executive obligation in terms of legislation, providing national government intervention powers in provinces to take 'appropriate steps' to ensure such obligations are fulfilled.[448]

On one hand, provinces are obligated to exercise authority over health services in both the Constitution and more specifically in terms of the NHA, as implementers of national health policies and deliverers of health services. The central hospitals are, however, underfunded and provincial health departments such as Gauteng are under financial pressure to run these hospitals which affects service delivery.[449] Therefore, the NDoH can intervene in the administration using section 100. Such an intervention however, should occur by taking 'appropriate steps' to ensure that the obligation to run central hospitals is fulfilled. Section 100(1) of the Constitution provides for two appropriate steps, namely issuing a directive to the provincial executive describing the extent of its failure with steps to meet its obligations and assuming responsibility of the obligation in that province to the extent necessary. The CC has held that the 'appropriate steps' constitutes

[447] *WC Premier* case, para 52.
[448] *WC Premier* case, para 53.
[449] Kahn T (2019) 1.

one process where the issuing of a directive should take place before the executive obligation is assumed.[450] The national government therefore has to issue a directive before it can assume the responsibility.[451] Moreover, the extent necessary for assuming the provincial executive obligation can be on one of four grounds. First, if assuming the responsibility is to maintain essential national standards by meeting the minimum established requirements for service delivery. Secondly, if such recourse is necessary to maintain economic unity. Thirdly, where the national government wants to maintain national security and fourthly, to prevent provinces from taking unreasonable action that could be prejudicial to the interest of another province or the country. If any of these grounds are present, the national government can temporarily take over the administration of central hospitals then the change could potentially pass constitutional muster. Therefore, it can also be argued that the national government can invoke a section 100 intervention for a specified period and during such time and after the intervention, build the administrative capacity of provinces to manage central hospitals. Moreover, such intervention requires the National Council of Provinces (NCOP) to be notified and to approve the intervention according to section 100(2) of the Constitution.

On the other hand, provinces only have the executive authority to implement the NHA to the extent that it has the administrative capability to assume such a responsibility effectively, according to section 125(3) of the Constitution. Therefore, if provinces are failing to effectively manage central hospitals, taking over the administration could also be constitutionally justified based on section 125(3) of the Constitution too. The takeover can be justified until the second half of section 125(3) of the Constitution is looked at. The second part provides that the national government must assist provinces to develop provinces' administrative capacity so that provinces can effectively perform

[450] *Certification of the Amended Text of the Constitution of the Republic of South Africa, 1996 (Second Certification* judgment) (CCT37/96) 1997 (1) BCLR 1 (CC), para 120.
[451] Murray C & Ampofo-Anti O 'Provincial executive authority' in Woolman S & Bishop M (eds) 2 ed *Constitutional Law of South Africa* (2014) 32.

their functions such as implementing national legislation. The national government has to assist provinces through 'legislative and other measures'.[452] This could be done through financial management training, since provinces are under financial pressure to run central hospitals.

4.2.2. Delivery of primary health care

Aside from the increase in health service delivery by administering central hospitals, the NDoH will also take over the delivery of PHC services, through the establishment of the district health management offices (DHMO).[453] With all these major increases, the pertinent issue is whether the national government is constitutionally permitted to increase its role in the actual delivery of health services.

Health services range from PHC services to highly specialised services.[454] Therefore, PHC services are included in the concurrent competence broadly listed as 'health services' under the Constitution. On one hand, based on section 44(1)(*a*)(ii) of the Constitution, it is argued that the national government is constitutionally permitted to increase its role in health services.[455] On the other hand, as argued above, the national government must exercise its power in a manner that does not encroach on the 'geographical, functional or institutional integrity' of provinces. Provinces are mainly responsible for the district health system (DHS) through which PHC services are delivered.[456] The NHI Bill proposes the establishment of DHMO, which is likely to replace the current DHS, to perform the function that provinces currently perform regarding PHC services.[457] The establishment of these nationally accountable DHMOs, significantly reduces provinces' power to deliver PHC services. Therefore, as argued above, the reduction of provinces' role in PHC materially detracts from provinces' ability to function in the health sector. Therefore, this

[452] Section 125(3) Constitution.
[453] Clause 36 *NHI Bill* (2019) 49.
[454] See section 2.4.2 ch 2.
[455] See section 4.2.1 ch 4.
[456] See section 2.4.2 ch 2.
[457] See section 3.5.2.2 ch 3.

reduction may be unconstitutional because provinces will likely be prevented from delivering PHC services.

The taking away of PHC services and central hospitals also means that the funding for these services will fall away because the funds follows the function. Provinces are dependent on central transfers for 97 per cent of their revenue.[458] The remaining three per cent comes from own revenue from processing applications (and granting liquor and gambling licenses) or gambling taxes (horse-racing and casinos).[459] Taking away of PHC services and central hospitals would further mean a substantial reduction in the PES. The reduction in the PES, coupled with taking over the administration of central hospitals and the delivery of PHC, is not only an encroachment into provinces' concurrent powers, but it would potentially strip provinces of such concurrent powers. Altogether, such changes could potentially be unconstitutional to the extent that they, could potentially prevent provinces from functioning fully and effectively in this concurrent space.

4.3. Conflict between national legislation and provincial legislation

In so far as the national government can increase its role in health services based on concurrency, the same is argued for provinces' ability to opt out of the NHI Bill if it is passed into law. Although there is an obligation placed on provinces to implement national legislation, if the Bill becomes law, provinces could find themselves in a tight corner with no room for innovative health policies.[460] Murray and Ampofo-Anti contend that provincial innovation is rare since provinces have limited capacity and are generally content with implementing national programmes that are

[458] De Visser J 'Concurrent powers in South Africa' in Steytler N (ed) *Concurrent Powers in Federal Systems: Meaning, Making, Managing* (2017) 227.
[459] Borgstrom D & Naidoo UK 'Playing with power: The competing competencies of provincial and local government' (2013) 6 *Constitutional Court Review* 62. Khumalo B, Dawood G & Mahabir J 'South Africa's intergovernmental fiscal relations system' in Steytler N & Ghai YP (eds) *Kenya-South Africa Dialogue on Devolution* (2015) 206.
[460] Powell (2015) 309.

set in strict parameters by the national government.[461] However, provinces are not obligated to implement national policies.[462]

Moreover, since provinces have equal law-making power and executive power in concurrent areas, provinces can pass their own health legislation for their province. According to section 104(1) of the Constitution, provinces have legislative authority to pass laws on any matter that falls within schedule 4A. This is a constitutionally conferred power, which cannot be changed except if this provision is revised through an amendment of the Constitution itself. Provinces' concurrent legislative powers enable provinces to lawfully depart from national legislation and make their own legislation in the same policy field such as health services. If, however there is a conflict between the provincial legislation, and the national legislation there is a qualified national override in terms of section 146 of the Constitution.

Provincial legislation will by default prevail over national legislation according to section 146(5) of the Constitution. National legislation will therefore not automatically prevail over provincial legislation, as section 146 is designed to protect provincial legislative autonomy.[463]For national legislation to prevail, in terms of section 146(2) of the Constitution, three general tests are provided.

First, if the national legislation deals with a matter that cannot be effectively regulated by legislation that provinces have enacted for their provinces, national legislation will prevail.[464] The NHI Bill is aimed at eliminating the unequal access to health care services across provinces, among other things.[465] It can be argued that in terms of this condition, the NHI Bill (if it becomes law) could prevail over provincial health legislation, as a national law is more likely to provide universal

[461] Murray & Ampofo-Anti (2014) 10.
[462] *National Education Bill* case, para 24.
[463] *Second Certification* judgment, para 109.
[464] Section 146(2)(*a*) Constitution.
[465] See section 1.1 ch 1 & section 3.1 ch 3.

access to health care across the country, as opposed to individual provincial laws which will only be applicable in provinces. Additionally, the capacity of each province differs, which is likely to perpetuate the inequalities to access to health care across provinces.

Secondly, national legislation will prevail if it deals with a matter that requires uniformity across the nation and the national legislation provides such uniformity by establishing 'norms and standards', 'frameworks' or 'national policies'.[466] The NHI Bill does purport to create uniformity of access to health services across provinces, however, such uniformity will not be done by establishing 'norms and standards', 'frameworks' or 'national policies'. Instead such uniformity will be through nationalising health services, by preventing provinces from delivering these services. Therefore, national legislation will not prevail, in terms of this condition.

Thirdly, the national legislation should be necessary for any of the grounds listed in section 146(2)(*c*) which ranges from maintaining national security or economic unity to promoting equal opportunity or equal access to government services. Under this condition, the NHI Bill could prevail over provincial legislation based on the necessity to provide equal access to government services, namely health services. This is submitted because section 146(2)(*c*)(v) provides for equal access to government services and since the aim of the NHI Bill is to provide equal access to all people to health services, despite socio-economic status, the NHI Bill could potentially trump provincial laws, based on this section.

In addition, section 146(3) provides that national legislation will prevail over provincial legislation if the national legislation is aimed at preventing unreasonable action by a province that is prejudicial to the economic, health or security interest of another province or the country; or if the provincial legislation will impede the implementation of national economic policy. Currently there is not any provincial legislation on health services, as provinces usually implement legislation in

[466] Section 146(2)(*b*) Constitution.

concurrent areas. Therefore, there is no unreasonable action by a province that is prejudicial to any of the interest mentioned above or that will likely impede the implementation of national economic policy.

If the NHI Bill is passed into law and a province also decides to pass its own health laws, section 146 of the Constitution which deals with conflicts between national and provincial legislation, will find application. Bronstein submits that before a conflict resolution can take place, certain steps have to be considered to determine if, indeed, there is a conflict.[467] First, the legislative competence of both the national and provincial legislation has to be established, namely whether the national legislation is 'competent and valid' and whether provincial legislation is 'competent and valid'.[468] If both the national legislation and provincial legislation are competent and valid, the next issue would be whether there is a conflict between the two.[469] If there is indeed a conflict between the two, section 146 of the Constitution becomes applicable to determine whether the national legislation can justifiably override the provincial law. It is submitted though, that the NHI Bill will not automatically trump provincial health legislation if it is enacted into law. It can be argued, however, that if the NHI Bill is passed into law, there is a possibility that it could trump any provincial health legislation (if provinces decide to use their legislative authority in schedule 4A matters), as it would likely meet section 146(2)(*a*) or section 146(2)(*c*)(v) of the Constitution, as argued above.

4.4. The constitutionality of the National Health Insurance Bill infringing on exclusive provincial functions

The definition of ambulance services differs across provinces, but is essentially about providing emergency patient transportation and pre-hospital care.[470] Regulation 1 of the Emergency Medical

[467] Bronstein V 'Reconciling regulation or confronting inconsistency? Conflict between national and provincial legislation' (2006) 22(2) *South African Journal on Human Rights* 285.
[468] Bronstein (2006) 285.
[469] Bronstein (2006) 285.
[470] See section 2.4.2 ch 2.

Services (EMS) regulations define ambulance as a motor vehicle that is 'appropriately equipped…solely for the purpose of emergency care and conveyance of patients' and 'owned by an Emergency Medical Service'.[471] Moreover, EMS is defined as 'an organisation or body that is dedicated, staffed and equipped to operate an ambulance, medical rescue vehicle or medical response vehicle in order to offer emergency care'. Ambulance services are an exclusive provincial function. As evident from above, ambulance services fall within the broadly construed EMS. Provincial health departments are currently responsible for public EMS. For example, the Western Cape EMS caters for 80 per cent of its uninsured population, and transports patients to 34 district hospitals, four regional hospitals and three central hospitals.[472] The Western Cape government is responsible for sustaining these services, paying EMS employees, purchasing and maintaining emergency vehicles and for the 'accreditation, registration and licensing of ambulance services', from its provincial budget.[473]

The NHI Bill construes ambulance services as 'ambulance services as contemplated in Part A of Schedule 5 to the Constitution'. This schedule 5A definition is likely referring to the same definition of ambulance as defined in Reg 1 of the EMS regulations above. The NHI Bill does not provide much detail to any changes to ambulance services, merely that ambulance services constitute what is contemplated in schedule 5A. The NHI Bill also provides that ambulance services will be reimbursed through the PES. Provinces will still receive some PES allocation for delivering ambulance services. However, according to clause 1 of the NHI Bill, EMS are defined as 'services provided by any private or public entity dedicated, staffed and equipped to offer pre-hospital acute medical treatment and transport of the ill or injured'. The definition of EMS includes functions that fall under ambulance services as highlighted above. This might indicate that there

[471] EMS regulations in GN 1320 *GG* 41287 of 1 December 2017.
[472] Allgaier RL, Laflamme L & Wallis LE 'Operational demands on pre-hospital emergency care for burn injuries in a middle-income setting: A study in the Western Cape, South Africa' (2017) 10(2) *International Journal of Emergency Medicine* 2.
[473] Preamble Western Cape Ambulance Act 2003.

is some intrusion into provinces' exclusive function regarding ambulance services. As such, the intrusion of national government needs to be justified under section 44(2) of the Constitution for it to pass constitutional muster, since the national government cannot enter exclusive functional areas of provinces without such justification.[474]

Section 44(2) of the Constitution provides five grounds for intervention into an exclusive provincial function through legislative means by Parliament. First, Parliament may intervene if it is necessary to maintain national security.[475] Secondly, intervention can be justified on the ground of maintaining economic unity.[476] Thirdly, according to section 44(2)(*c*) of the Constitution, Parliament may intervene if it is necessary to maintain essential national standards. Fourthly, section 44(2)(*d*) of the Constitution provides that Parliament may intervene because it is necessary to maintain essential national standards for the rendering of services. Fifth, Parliament may intervene to 'prevent unreasonable action taken by a province which is prejudicial to the interest of another province or to the country as a whole'.[477] Section 44(2) of the Constitution imposes a high threshold as legislative intervention must be 'necessary' on any of the abovementioned grounds.[478] This limits Parliament's intervention power and ensures that provinces' exclusive power remains intact outside of these limits and beyond Parliament's legislative competence.[479]

The *Ex Parte President of the Republic of South Africa: In re Constitutionality of the Liquor Bill* (*Liquor Bill* case)[480] is the main judgment that deals with the interpretation of exclusive competence of provinces.[481] The *Liquor Bill* case involved a national Liquor Bill that sought to regulate the production, distribution and sale of liquor including the license thereof. Since

[474] See section 2.2 ch 2.
[475] Section 44(2)(*a*) Constitution.
[476] Section 44(2)(*b*) Constitution.
[477] Section 44(2)(*e*) Constitution.
[478] *Certification of the Constitution of the Republic of South Africa, 1996 (First certification judgment)* (CCT23/96) 1996 (4) SA 744 (CC), para 257.
[479] *First Certification* judgment, para 527.
[480] *Liquor Bill* case (CCT12/99) [1999] ZACC 15 (CC).
[481] Bronstein V 'Envisaging provincial powers: A curious journey with the constitutional court' (2014) 30 *South African Journal on Human Rights* 28.

provinces have exclusive power regarding 'liquor licenses', the President, had reservations about the Bill's constitutionality and referred it to the CC. The CC had to decide whether the Liquor Bill is constitutional and can be justified under section 44(2) of the Constitution to interfere with province's exclusive competence of 'liquor licenses'. The CC in analysing schedule 5 matters, used a functional approach which involved looking at the overall constitutional scheme,[482] and distinguished whether matters are to be regulated inter-provincially or intra-provincially.[483] The CC found that the Liquor Bill intruded onto provinces' exclusive function of retail liquor licensing, as this is a function better regulated intra-provincially, and declared the Liquor Bill unconstitutional.[484]

The meaning of the functional areas in the schedules are, as a final analysis, determined by the courts.[485] Interpreting functional areas is a question of legal principle and not a political one.[486] The determining factor in the interpretation is where both national and provincial legislatures can exercise their powers fully and effectively.[487]

Steytler and Fessha suggest an interpretation of exclusive powers first, where exclusive power given to one sphere is singled out from the full range of government powers.[488] Simply put, in relation to EMS, Steytler and Fessha's approach would mean defining ambulance services first then defining the remainder of EMS. This is a favoured approach, as it would also mean affording more protection to provinces' function regarding ambulance services. Moreover, in taking such an approach, the constitutionality of the proposed change regarding EMS becomes contentious. This would mean that the proposed change to separate ambulance services from EMS and in turn having

[482] *Liquor Bill* case, para 47.
[483] *Liquor Bill* case, para 52.
[484] *Liquor Bill* case, para 87.
[485] Steytler & Fessha (2007) 324.
[486] Steytler & Fessha (2007) 325.
[487] *Western Cape Provincial Government and Others: In re DVB Behuising (Pty) Ltd v North West Provincial Government and Another* (*DVB Behuising* case) 2001 (1) SA 500 (CC), para 17.
[488] Steytler & Fessha (2007) 331.

the Fund pay EMS providers would need to be justified under section 44(2) of the Constitution. This will be dealt with below.

Moreover, Steytler and Fessha use the functional approach promoted in the *Liquor Bill* case to determine whether a matter is best suited to be regulated intra- or inter-provincially in the context of a functional area. They apply this functional approach to municipal activities. They argue that the context of the functional area ought to be looked at to determine what constitutes intra-municipal.[489] Steytler and Fessha argue that the purpose of a thing or service, or place plays an important role in this determination.[490] They use a road as an example and contend that if the purpose of the road is to link two or more municipalities, the road has an extra-municipal dimension and should be viewed as provincial.

The purpose of EMS is to provide acute pre-hospital care while transporting patients to different levels of care facilities (such as from community health centres to a district hospitals).[491] Moreover, using the Western Cape EMS as highlighted above as an example, these services transport patients between hospitals that exist within the province and are usually connected by EMS transportation, either on land or by air. These services are by definition intra-provincial. This intra-provincial dimension of EMS generally applies for the other 8 provinces too.[492]

EMS providers will be paid on a capped case-based fee under the proposed NHI scheme.[493] Capped fees are characterised by a lump sum arrangement. If the 'cap' is not reached, only payment for the work done will be reimbursed. This means that EMS providers will be assessed and paid based on a case by case basis.[494] Additionally, the Fund will assess whether the contracted EMS providers

[489] Steytler & Fessha (2007) 333.
[490] Steytler & Fessha (2007) 334.
[491] See section 2.3.2 ch 2.
[492] See section 2.3.2 ch 2 for the Free State province's definition of EMS.
[493] Clause 35(4)(*a*) *NHI Bill* (2019) 20.
[494] Galea D & Bailey A 'The art of maximising value – creating alternative fee arrangements' available at *https://incegd.com/en/knowledge-bank/the-art-of-maximising-value-creating-alternative-fee-arrangements* (accessed 11 November 2019) 1.

have delivered the services in terms of their contractual obligations, including a reporting procedure to the Fund that must take place.[495] Therefore, funding could be delayed in certain instances or not given if the Fund is strict about the procedures for reimbursement to be followed. The Fund will be responsible for reimbursing provincial EMS providers. Therefore, the NHI Bill does, intrude onto provinces' function regarding EMS and thus ambulance services that falls within this definition. The national sphere will be providing funding to public EMS providers, namely provinces, but it will not be through an annual division of revenue allocation process, instead on a capped-case based fee.

This intrusion will need to be justified under section 44(2) of the Constitution. Paying EMS providers on a capped fee case basis is not a necessary for maintain national security, therefore section 44(2)(*a*) of the Constitution cannot be relied on for justification. Moreover, the NHI Bill regarding the change to EMS is not to prevent any unreasonable action by provinces as there has been no unreasonable action taken by provinces regarding EMS. The intrusion is also not necessary to maintain economic unity. It is argued that the intrusion onto EMS and essentially ambulance services, could be justified under section 44(2)(*c*) of the Constitution. This is argued because the NHI Bill is aimed at providing essential national standards regarding health service delivery including EMS and to achieve universal health coverage (UHC) which includes eliminating the fragmentation of health care funding as a result of the fiscal federal system currently in place.[496] Moreover, it is argued, that paying EMS providers can also be justified according to section 44(2)(*d*) of the Constitution, which provides for the establishment of minimum standards for rendering EMS. EMS delivery differs across provinces. Parliament can therefore justify the enactment of the NHI Bill using section 44(2)(*d*) of the Constitution.[497] Therefore, the intrusion

[495] Clause 39(5) *NHI Bill* (2019) 22.
[496] Preamble *NHI Bill* (2019) 3. See section 1.4 ch 1.
[497] See section 2.2.2 ch 2.

onto EMS and therefore ambulance services can pass constitutional muster for the reasons argued above.

4.5. Constitutionality of the changes in local government's role under a National Health Insurance

In practice, local government's role in health services is largely confined to environmental health services.[498] However, metropolitan municipalities do have some hand in PHC services. With the proposed change of the DHMO taking over the control and delivery of PHC services, metropolitan municipalities' power, in theory, could be reduced. Steytler and Fessha assert that municipalities that have historically provided a service will not give up the provision of that service easily.[499] This appears to be true for metropolitan municipalities that continue to provide PHC services alongside provinces, because metropolitan municipalities will not easily give up the provision of PHC.[500] With PHC services being centralised under the NHI Bill to the nationally accountable district health management offices (DHMO), at issue is whether such centralisation is constitutional regarding local government functions.

National and provincial government can regulate schedule 4B functional areas, although these regulation powers are limited by sections 155(6) and (7) of the Constitution. Moreover, these regulations cannot go beyond setting norms and standards for municipalities so municipalities can perform their functions effectively or to monitor or support municipalities.[501] The NHI Bill does not provide much regarding any changes to municipal health services as the NHI Bill is mostly directed at personal health services as opposed to environmental.

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[498] See section 2.4.3 ch 2.
[499] Steytler & Fessha (2007) 323.
[500] See section 2.4 ch 2.
[501] *Habitat Council and Others; Minister of Local Government, Environmental Affairs and Development Planning, Western Cape v City of Cape Town and Others* (CCT117/13) [2014] ZACC 9 (CC), para 22. De Visser (2017) 226.

Therefore, since metropolitan municipalities do provide PHC services in practice, but PHC services are not allocated to them in the narrowly defined 'municipal health services' under the Constitution, it is argued that the centralisation of PHC services would likely be constitutional.

4.6. Conclusion

It is evident from this chapter that the NDoH will essentially place all health services under its control. The issue that had to be discussed was whether the proposed reorganisation of the current public health system and the change of the role of each sphere of government in this system would pass constitutional muster. The first section dealt with the constitutionality of NHI proposed changes by national government exercising its concurrent powers regarding health services. First, the constitutionality of the change in the administration of central hospitals and taking over PHC delivery from provinces was argued to potentially be unconstitutional as it will substantially reduce provinces' autonomy to function fully and effectively regarding their concurrent power in relation to health services. Secondly, it has also been argued that the NHI Bill, once passed into law, could trump any provincial health laws that may contest it, in terms of section 146(2)(*a*) or section 146(2)(*c*)(v) of the Constitution.

Thirdly, it has been examined whether the NHI Bill intrudes onto provinces' exclusive function regarding ambulance services. It has been argued that there is an intrusion onto ambulance services because of ambulance services falling within the broad definition which of EMS which the NHI Bill proposes changes to. The constitutionality of provinces' intruding on EMS and essentially ambulance services therefore had to be examined using section 44(2) of the Constitution which provides the grounds for legislative intervention from the national sphere into schedule 5A. It has been argued that the NHI Bill could be justified as being necessary to maintain essential national standards regarding EMS or to establish minimum standards for rendering EMS according to sections 44(2)(*c*) or 44(2)(*d*) of the Constitution, respectively.

Finally, regarding local government, it has been argued that centralising PHC services could pass constitutional muster as PHC services do not fall within the ambit of 'municipal health services'. The next chapter will deal will draw conclusions based on a collective analysis of the previous chapters. The chapter will further make recommendations in light of the findings of this chapter.

CHAPTER 5: CONCLUSION

5.1. Introduction

The aim of this thesis was to assess the constitutionality of the NHI Bill, particularly regarding the changes to subnational governments' role in health service delivery. This assessment was done by focusing on the constitutionality of selected proposed changes by analysing the Constitution, particularly schedules 4 and 5. These selected changes include the proposed change in the administration of provincially owned 'central' hospitals, transferring primary health care (PHC) service delivery from provinces to the national government and the intrusion of the national government into ambulance services - an exclusive provincial function.[502] Case law concerning concurrent and exclusive powers and functions of provinces has been used. Literature was heavily relied on to substantiate the argument presented in this thesis. Considering the previous chapters, it is important to consider ways to improve and protect provinces' role in the multi-level government space. Health service is one of two major socio-economic competences in which provinces still exercise significant power.[503] This chapter will summarise the findings of each chapter and will provide recommendations regarding the future role of provinces in the health sector.

5.2. Health services in law and practice

In terms of schedule 4A of the Constitution, national and provincial governments have concurrent powers regarding health services, although the specific responsibilities are not clearly delineated. Local government also has concurrent powers regarding health services, which is termed 'municipal health services'.[504]

[502] Clauses 7(2)(*f*), 36 & 35(4)(*a*) Ministry for Health *National Health Insurance Bill* (*NHI Bill*) (published in *GG* 42598 of 26 July 2019), respectively.
[503] See section 2.4.2 ch 2 and section 4.2 ch 4.
[504] Schedule 4B Constitution.

The National Health Act (NHA) delineates the extent of each sphere's responsibility as follows:

- National government initiates health policies and oversees the public health system.[505]
- Provincial health departments are the main providers of all levels of personal health care ranging from primary health care (PHC) to specialised care.[506]
- Local governments ought to provide PHC services through a district health system (DHS), which was placed under the control of provincial health departments. Local government is responsible for non-personal health care namely, environmental health services.[507]

In practice, although provinces deliver all levels of personal health services, metropolitan municipalities have resisted the provincialisation of PHC services, which district and metropolitan municipalities delivered prior to the enactment of the NHA.[508] This resulted in provinces and metropolitan municipalities providing PHC services, usually through partnership agreements.

Additionally, there are challenges present in the public health system and health service delivery. These problems range from weak supervision at all levels of government, ill-trained health practitioners, dilapidated public clinic and hospital infrastructure, financially distressed provincial health departments to name a few, which results in poor health service delivery.[509]

5.3. Changes under a National Health Insurance Bill

The main changes that will take place according to the NHI Bill at national level include the transferral of the administration of central hospitals from provincial health departments to the National Department of Health (NDoH).[510] The NDoH will also take over the delivery of PHC services from provinces and metropolitan municipalities through the establishment of district

[505] See section 2.3.1 ch 2.
[506] See section 1.1 ch 1 and section 2.3.2 ch 2.
[507] See section 2.3.3 ch 2.
[508] See sections 2.4.2 & 2.4.3 ch 2.
[509] See section 1.1 ch 1 & section 2.4 ch 2.
[510] See section 3.5.1 ch 3.

health management offices (DHMO) that will be directly accountable to the NDoH.[511] The NDoH will also be responsible for paying public EMS providers which is currently the prerogative of provinces.[512]

It has been observed in chapter three, that the bulk of changes proposed by the NHI Bill are aimed at provinces. Provinces are failing to deliver adequate health services and the fiscally devolved manner of funding health services is said to contribute to this failure.[513] The national government has proposed an NHI to serve as the solution to provinces' failure amongst other reasons.[514] Although not explicit, the increase of national government's role regarding the actual delivery of health services implies a decrease in provinces' role as the main providers of health services.

5.4. Constitutionality

At the heart of this thesis was determining the constitutionality of the reduction to subnational governments' role in health service delivery, particularly provinces. The increase in national government's role from policymaking to delivering health services was looked at first. It has been argued, on one hand, that the taking over of the administration of central hospitals by national government could be unconstitutional as it substantially reduces provinces' power in relation to health services to a point that prevents provinces from functioning in this concurrent domain.[515] On the other hand, it has been submitted that the national government can constitutionally justify the taking over of the administration of central hospitals by invoking a temporary administrative intervention in terms of section 100 of the Constitution. However, a certain procedure must be followed for invoking such an intervention including notifying and getting the approval of the National Council of Provinces (NCOP).[516] This administrative intervention route does not seem to

[511] See section 3.5.2 ch 3.
[512] See section 3.5.2 ch 3.
[513] See section 1.1 ch 1.
[514] See section 3.3.2 ch 3 for additional reasons such as social solidarity.
[515] See section 4.2.1 ch 4.
[516] See section 4.2.1 ch 4.

have been followed, as the national government opted to initiate the NHI Bill instead. Additionally, the taking over of PHC service delivery from provinces could potentially be unconstitutional as it materially detracts from provinces' functional integrity regarding health services.[517] Moreover, where the function shifts, the funds follow. This means that provinces will no longer receive the health portion of the PES which makes up a third of provinces' budget.[518]

It has also been submitted that provinces can opt out of the proposed NHI-run health system by passing their own health legislation in terms of section 104(1) of the Constitution.[519] It has been argued, however, that the NHI Bill (if it is passed into law) will trump any provincial health legislation that may contest it based on section 146(2)(*a*) and section 146(2)(*c*) of the Constitution.[520]

Moreover, the intrusion on EMS and therefore ambulance services was argued to be constitutional as the intrusion by national government can be justified under section 44(2)(*c*) or section 44(2)(*d*) of the Constitution as being necessary to maintain essential national standards or establishing minimum standards for EMS delivery by provinces.[521]

Additionally, local government's potentially reduced role in PHC delivery could pass constitutional muster since in practice, only metropolitan municipalities deliver PHC services in the local government sphere. PHC services have not been allocated to metropolitan municipalities in the Constitution and does not form part of 'municipal health services', as PHC services does not fall under the definition of 'municipal health services'.[522]

[517] See section 4.2.2 ch 4.
[518] See section 1.3 ch 1.
[519] See section 4.3 ch 4.
[520] See section 4.3 ch 4.
[521] See section 4.4 ch 4.
[522] See section 4.5 ch 4.

5.5. Recommendations

5.5.1. Constitutionality

The NHI Bill has been argued to potentially be unconstitutional as it will likely encroach on provinces' functional integrity and thus prevent them from exercising their concurrent power in relation to health services. Moreover, provinces' opting out of an NHI-system will likely prove futile as the NHI Bill (if passed into law) will trump any provincial health legislation that may contest it. Provinces' role in the multilevel government is deteriorating and the passing of the NHI Bill into law is likely to exacerbate this reduction of provinces' role in concurrent functional areas. It is therefore suggested that the NHI Bill should be referred to the Constitutional Court (CC), first, for a final determination of the NHI Bill's constitutionality. In terms of section 167(4)(*b*) of the Constitution, the CC may only decide on the NHI Bill's constitutionality if the President has reservations about the NHI Bill that have not been accommodated by both houses of Parliament. The President can then refer the NHI Bill to the CC to decide on the NHI Bill's constitutionality.[523] Moreover, if the CC decides that the NHI Bill is constitutional, the President must assent and sign the NHI Bill. This will create much needed legal certainty around the constitutionality of this controversial NHI Bill. In the event the CC makes a finding that the NHI Bill is constitutional, it is suggested that instead of nationalising health services, provinces' current role should be maintained and provinces' capacity to deliver adequate, quality health care services should be improved, as suggested below.

5.5.2. Financial

Instead of reorganising the entire public health sector, certain improvements could be made as an alternative and to protect provinces' functional integrity regarding concurrent powers. This includes improving the current role of national government in stewarding the public health system.

[523] Section 79(4)(*b*) Constitution.

This ought to be done by the national government ensuring the effective and efficient functioning of the lower levels and supporting these levels.[524] There should be an improvement in national government's monitoring of provinces in the delivery of health services, as provinces are responsible for implementing the NHA, which is national legislation.[525] It is recommended that monitoring could be improved by having regular performance reporting from provinces. Importantly, since provinces are said to be fiscally distressed or merely lacking in fiscal performance, financial monitoring and reporting mechanisms of provinces should be improved by national government. Fiscal stress is broadly defined as the manifestation of service delivery problems that is transmitted through the budget not only from financial and economic factors, but also political, institutional, legislative and structural factors.[526] Regarding the PES, the national government ought to monitor and help provinces to spend their PES on delivering provinces' constitutional mandate, in a manner that is not too invasive on provinces' financial autonomy.[527] National and provincial treasuries also need to improve the assessment frameworks against which provinces are evaluated.[528] Additionally, the national treasury has to improve monitoring and accountability mechanisms to ensure conditional grants transferred to provinces are spent on what they are granted for. Moreover, the Auditor-General (AG) is the supreme audit institution and is responsible for the auditing and reporting on the accounts and financial management of provincial state departments, among others.[529] Where there are consistent contraventions of the Public Finance Management Act, the AG, through the rigorous enforcement of the AG's powers in terms

[524] See section 3.5.1.2 ch 3.
[525] See section 2.2 ch 2.
[526] Financial and Fiscal Commission (FFC) Policy Brief *Assessing and Improving the Fiscal Performance of Provinces in South Africa* (2013) 2.
[527] Khumalo B, Dawood G & Mahabir J 'South Africa's intergovernmental fiscal relations system' in Steytler N & Ghai YP (eds) *Kenya-South Africa Dialogue on Devolution* (2015) 215.
[528] FFC (2013) 2.
[529] Section 4(1)(*a*) Public Audit Act 25 of 2004.

of section 5(1B) of the Public Audit Amendment Act ought to be relied on.[530] These powers include the AG taking any appropriate remedial action.[531]

Moreover, a pragmatic approach needs to be developed, as nationalising central hospitals or the entire health care system for that matter, will not necessarily result in more efficiency or a better financial position. The duplication of services is likely to occur or more money will be spent on administration as opposed to getting more health professionals. The NDoH does not have the experience in the actual delivery of health services as provinces do, despite provinces' failures.[532] The NDoH will need to build up its capacity to administer central hospitals and the capacity of the DHMO, which could result in more money being spent on administration as opposed to health needs of the population. Therefore, it is recommended that increasing capacity-building grants to provincial governments to enable them to provide better training to health professionals, and building up the current public health system instead of reorganising the entire system, should be done.

5.5.3 Intervention

Additionally, national government can invoke a section 100 intervention in terms of the Constitution. This would be a temporary administrative takeover of provincial health departments that are failing, without encroaching on provinces' functional integrity permanently.[533] Moreover, the administrative capacity of provinces that are failing to deliver health services can be built up, while the national government temporarily takes over the administration of central hospitals or PHC. This suggestion is more in the line with the spirit of multi-level governance and also protects provinces' functional integrity.

[530] Act 5 of 2018.
[531] Section 5(1B)(*a*) Act 5 of 2018.
[532] See section 7.1 ch 3.
[533] Section 4.2 ch 4.

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