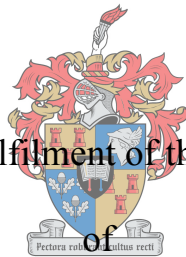


A decent minimum of health care in South Africa: a bioethical proposal

By

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Declaration of own work

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English abstract

In this thesis I identify some of the major challenges faced by the current health care system of South Africa. Thereafter conceptual analyses are done with regards to what is meant by a health care system and a decent minimum of health care (DMOHC). Although several questions around possible causes of the challenges are identified, I focus on one specific question: Is the health care system chosen for South Africa able to facilitate the service delivery expected of it? And if not, how should it be amended to achieve satisfactory results?

A problem statement containing three main questions is formulated:

Problem 1: Is a DMOHC in principle a good idea?

Problem 2: Is a DMOHC a good idea for South Africa?

Problem 3: If so, what ought that decent minimum to be?

With regards to question three, I propose three main changes:

1. Prioritize and ration health care services at a policy level.
2. Integration of the public and private health care sector, by utilizing the National Health Insurance (NHI).
3. Innovations in regulating and taxing the private sector.

Arguments in favour of and against each of the concepts are discussed, with conclusions being made at the end of each deliberation process. In this thesis I find that a DMOHC is in principle a good healthcare system

and also a good system for South Africa. With regards to the proposed changes, I strongly support prioritizing and rationing health care services at policy level. The NHI will probably soon be supported with legislation and its implementation is imminent. Whether its proposed structure will be a success, is uncertain and I am highly sceptical of its lofty goals. I do not suggest the implementation of my third set of changes, although I do think a super tax on excessive profits made by health-related businesses is more palatable than additional taxes on the general community.

Afrikaanse opsomming

In hierdie tesis identifiseer ek van die mees vernaamste uitdagings wat deur die Suid-Afrikaanse gesondheidstelsel ondervind word. Daarna doen ek konseptuele ontledings van wat bedoel word met 'n gesondheidstelsel en 'n "decent minimum of health care" (DMOHC) (behoorlike minimum van gesondheidsorg). Alhoewel daar verskeie vrae rondom moontlike oorsake van die uitdagings geïdentifiseer is, fokus ek op een spesifieke vraag: Is die gesondheidstelsel wat gekies is vir Suid-Afrika daartoe in staat om die gesondheid sorg te fasiliteer wat verwag word? En indien nie, hoe moet die stelsel aangepas word om die gewenste resultate te bewerkstellig?

'n Probleem stelling wat drie hoof vrae bevat is geformuleer:

Probleem 1: Is 'n "DMOHC" 'n goeie sisteem in prinsiep?

Probleem 2: Is 'n "DMOHC" 'n goeie sisteem vir Suid-Afrika?

Probleem 3: In dien wel, wat sou 'n behoorlike minimum wees?

Met betrekking tot die derde vraag, maak ek drie hoof voorstelle:

1. Prioriseer en ransoneer gesondheidsdienste op 'n beleids vlak.
2. Integrasie van die publieke en privaat gesondheids sektore deur die Nasionale Gesondheidsversekering.
3. Innoverende gereguleering en belasting van die privaat gesondheids sektor.

Argumente vir en teen elkeen van hierdie voorstelle is bespreek en afleidings is aan die einde van elkeen van hierdie prosesse gemaak. In hierdie tesis bevind ek dat 'n "DMOHC" in prinsiep 'n goeie gesondheidstelsel is en ook 'n goeie stelsel vir Suid-Afrika is. Met betrekking tot die voorgestelde veranderinge, ondersteun ek ten sterkste die priorisering en ransonering van gesondheidsorg dienste op beleids vlak. Die nasionale gesondheidsversekering sal waarskynlik binne kort deur wetgewing ondersteun word en geïmplementering word. Of die voorgestelde struktuur van die Nasionale gesondheidsversekering suksesvol gaan wees, is onseker en ek is baie skepties oor die doelwitte wat bereik wil word. Ek ondersteun nie die implementering van my derde stel van voorgestelde veranderinge nie, maar ek dink tog dat 'n addisionele belasting op oormatige winste gemaak deur gesondheid verwante besighede, meer aanvaarbaar is as addisionele belasting op die algemene publiek.

Chapter one

Introduction

1.1. Challenges faced by the health care system of South Africa

I would like to start where Prof. Solly Benatar ends his article: *"The challenges of health disparities in South Africa"*. His closing paragraph perfectly summarises the current situation faced by the South African health care system.

"The challenge is to narrow disparities and to generate opportunities for much more people to survive childhood, reach full human potential and lead healthy, productive lives. Achieving these ambitious goals requires actively striving for the social infrastructure for a healthy population, and for innovative ideas and actions in a balanced healthcare system. The still-evolving global economic crisis, resulting from unbridled consumption prompted by dogged pursuit of flawed economic theory with accompanying widespread fraud and corruption, poses threats to health from widening disparities, climate change, and environmental degradation. These are stark reminders of the need for new values beyond those perpetuated by prevailing market rhetoric and current ideology." (Benatar 2013: 154-155)

Is Prof. Benatar's view justified? I will argue that it is, on the following ground:

There are significant disparities in health care outcomes between white and black people, in South Africa.

"In 2005, infant mortality rates ranged from 18/1 000 live births among white people to 74/1 000 among black people, which was much the same as rates in the early 1990s." (Benatar 2013: 154-155)

There is massive inequity in healthcare spending between the public and private sector:

"with annual per capita healthcare expenditure as disparate as \$150 (R1 200) in the public sector serving 84% of the population, and \$1 500 (R12 000) in the private sector for 16% of the population," (Benatar 2013: 154-155)

We have regressed in our ability to improve healthcare in certain areas:

"Overall maternal mortality increased from 150/100 000 pregnancies in 1998 to 650/100 000 in 2007." (Benatar 2013: 154-155)

We are failing to deliver effective healthcare in the fight against HIV.

"South Africa comprises almost 17% of the world's population living with HIV/AIDS. The country has the largest antiretroviral treatment programme in the world, yet only 40% of eligible adults are receiving treatment." (Benatar 2013: 154-155)

South Africa, like most developing countries, has limited health care resources. Not only do we have limited health care resources, but there are strong indications that the resources will decrease in the future.

Revenue to fund the health services in the public sector comes mainly from money collected through taxes. For an increase in tax-income, we need an increase in economic growth of the country, which is measured by the Gross Domestic Product (GDP).

"GDP Growth Rate in South Africa averaged 2.90 percent from 1993 until 2016" (Trading Economics 2017)

This means that if we assume that the government allocates roughly the same portion of their money annually to healthcare, then the money available for healthcare is on average 2.9% more every year. Thus they can provide 2.9% more services.

Now we need to ask: What is the approximate annual increase needed for services? This, of course, is something the health economist will be able to answer best and there are certainly many factors to consider, such as burden of disease, etc. Lets, just for now, use population growth as a

yardstick. In 2007 the South African population was around 48.91 million and in 2016 it was around 55.91 million. That means there was an average yearly population growth of 1.43% over the 10 year period.

(Trading Economics 2017) This would mean that the 2.9% GDP increase would cover the 1.43% population growth, only if there were no inflation.

From 1968 to 2017 the South African inflation rate averaged 9.19% per year. In the first quarter of 2017, the inflation rate was between 6.6% and

6.1%. (Trading Economics 2017) This essentially means that we need around 6% more money this year than we needed last year to do the same amount of work. (Let's, for argument sake, pick 6% as our inflation rate.)

Thus, if there was no population growth, it means that the 2.9% growth in GDP was 3.1% less than inflation (and more than 6% less than inflation if we use the average inflation rate of 9.19%). This means that even though there is economic growth, our country is annually becoming poorer and we actually have less money than we had the year before, to pay for services like health care.

Unless money is taken away from other sectors, such as education, social grants or security, and added to the healthcare budget, it means that we will not be able to fund the same healthcare services as we did the year before. On top of that, there has been an annual, population growth of around 1.43% and therefore an increase in the need for health services.

This compounds the problem.

We cannot function under the illusion that we can continue to expand the health care services, when in fact we cannot even sustain the current services. We actually have to decrease them.

Even if we have an increase in revenue, we still need an effective health care system and good management of healthcare resources, which seems to be lacking:

I would like to prove my point by discussing the link between GDP and life expectancy:

"Gross domestic product (GDP) is a monetary measure of the market value of all final goods and services produced in a period (quarterly or yearly)." (Wikipedia 2017) Per Capita GDP is the GDP of a country, divided by the number of people in the country and can be used to measure the wealth of a country.

Life expectancy can be used to measure the effectiveness of a health care system. When a country becomes wealthier, the improvement in health care, education, and housing (amongst other things) will all lead to better health, a decrease in mortality and an increase in life expectancy.

However, Biciunate condends that the most obvious reason why life expectancy increases as a country become wealthier is the effect of food supply on mortality. The improvement in the country's economy results

The Preston curve: life-expectancy versus GDP per capita

A scatter plot illustrating the relationship between GDP per capita and life expectancy. The x-axis represents GDP per capita in 2000, adjusted for purchasing power parity (PPP), ranging from 0 to 40,000. The y-axis represents life expectancy in 2000, ranging from 40 to 80 years. A positive correlation is shown by a red trend line. Data points are represented by orange circles of varying sizes. Several countries are labeled with arrows pointing to their respective data points.

Country	GDP per capita (approx.)	Life expectancy (approx.)
Botswana	6,000	39
Nigeria	2,000	47
Namibia	8,000	46
South Africa	10,000	48
Gabon	7,000	52
Equatorial Guinea	18,000	51
Bangladesh	2,000	58
Pakistan	3,000	59
Indonesia	4,000	61
India	1,000	65
Russia	10,000	65
Brazil	8,000	68
Mexico	6,000	75
Korea	18,000	73
Argentina	15,000	74
Spain	18,000	78
Italy	22,000	78
UK	25,000	77
France	26,000	78
Germany	28,000	76
Japan	27,000	81
USA	35,000	77

"Above is the Preston curve of life expectancy at birth" (Global History
@ LSE 2010)

Biciunaite also note, that unfortunately, a rise in Per Capita GDP does not guarantee an increase in life expectancy. *"Average life expectancy in South Africa, for example, dropped from 62 to 51 years over 1992-2005 despite the fact that per capita GDP grew almost seven-fold during that period."* (Biciunaite 2014) This is due to severe income inequalities. The increase in wealth is mainly experienced by the already wealthy, who simply become even richer, while the increase in wealth for the majority of the population is minimal. (Biciunaite 2014)

I would like to point out that according to the Preston Curve of 2000, shown earlier, in 2000 we had a higher GDP per capita than China, India, Brazil, and Russia, yet they had a much higher life expectancy. This emphasizes the impact of the severe income inequalities in South Africa and questions the effectiveness of our current health care system.

Then there is the impact of South African politics on the country's delivery of health care:

South Africa's health care system is over-exposed to political influence. The head of the health care of South Africa is the Minister of Health, who is a politically appointed person, and who reports to the President. Each province has two heads of health care, for that province. The MEC for

health, who is the political head and the Superintendent General (if it is a medical doctor) who is the clinical head. All clinical personnel will be reporting back to these heads and they will strategically lead and monitor the health care services of that province.

Therefore, the various political heads have immense power over the direction in which health care services are driven. This power can be to the detriment of the public, as seen during the time of the apartheid regime. Gilbert and Gilbert reports, that the South African government was then focussing its healthcare resources mainly on tertiary, curative care. Unfortunately, they were catering mainly for the white minority who held the political and economic power. When the World Health Organization introduced the Health For All (HFA) principles and advocated the Primary Health Care (PHC) approach, which was desperately needed among the black community, the government of the time did not show much interest. This, unfortunately, lead to many unnecessary deaths, due to curable diseases, simply due to the lack of sufficient primary healthcare. (Gilbert & Gilbert 2003)

On the other hand in the late nineties, both the President, Mr. Thabo Mbeki and the Minister of health, Dr. Manto Tshabalala-Msimang, did not accept that HIV caused AIDS, even though the official government

policy of South Africa said otherwise. Dr. Manto Tshabalala-Msimang went further to oppose the provision of Zidovudine (AZT), an antiretroviral medication, to HIV-positive pregnant women. This medication was shown to significantly reduce the transmission of the HIV virus from the mothers to their unborn babies. She argued that the drug was toxic, although there was little scientific evidence to prove it. It was only in 2002, that the South African High Court, ordered the Department of Health to make ¹Nepravine (sic), another antiretroviral drug, available to HIV-positive pregnant women. (South African History Online 2016)

These are only two examples of very direct political influence, but the true impact of politics on health care is much more far-reaching. If the president replaces the Minister of Finance and the rand devalues, the cost of all imported medical products rises immediately, but the health care budget remains the same. That means that the ability to render the health care services planned for has been diminished.

The impact of malpractice litigation also had devastating effects on the health care system of South Africa:

¹ Nepravine is probably spelled incorrectly and should have been Nevirapine.

James reports that in the four years leading up to 2015, the South-African department of health spent R1,2 billion on legal cost with regards to medical malpractice. In 2012 the litigation costs were R190,6 million and it rose to R388,7 million in 2015 an escalation of 35% per year! In 2014 KwaZulu-Natal spent R209,1 million, the Eastern Cape R91.9 million and Limpopo R30,9 million on litigation costs. Birth-related injuries like brain damage, especially cerebral palsy, accounts for the highest portion of the claims against the government hospitals. Minister Motsoaledi blamed the litigating lawyers' fraternity of 'unprofessional conduct' and 'excessive charges'. He proposed that a limit is set on malpractice payouts. (James 2015)

The costs incurred by the department of health due to litigation could have been spent on saving lives. One pay-out of several million could save many children dying from treatable illnesses.

**Further comments on the current healthcare status of South Africa
by a industry leader:**

Jonathan Broomberg, the CEO of Discovery Health, also makes this informative comment in his online article: *"Solving healthcare challenges in South Africa."*

Broomberg argue as follows: *"it is critical to note that health system challenges are not separate from the other challenges outlined by NPC.*

For instance:

High levels of unemployment undermine potential tax revenue and therefore limit funding for public healthcare;

The public health sector constitutes a large portion of the civil service and therefore exhibits many of its problems as outlined by the NPC: weak productivity, accountability and capacity; high levels of corruption; and policy and organizational instability;

Divisions in society in terms of access to quality healthcare reflect the more fundamental division in society between the rich, who tend to be able to use private healthcare, and the poor, who largely rely on public services. This is morally and politically unacceptable." (Broomberg 2011)

From this information I conclude the following:

1. The severe economic inequalities between the rich and the poor fundamentally pose the biggest threat to health care outcomes. South Africa needs economic growth and job creation on a large scale if we are to see a significant improvement in health care outcomes.
2. Even in our current economic environment, there is significant room for improvement in the healthcare service delivery in South Africa.

3. We cannot blame limited resources alone for the failures in health care outcomes. The Preston curve clearly shows how countries like Brazil are out-performing South Africa, even though we have roughly the same GDP.

4. South Africa's poor economic growth and high inflation rate pose major risks for the future delivery of healthcare services.

5. There needs to be a lot of work done in improving ethical conduct and managerial skills in the public sector, which includes the health services.

Taking these facts into consideration, I now ask: Is the health care system currently in use, the correct one for South Africa?

1.2. Conceptual analysis of a decent minimum of health care (DMOHC)

In order to structure the conceptual analyses, I will attempt to answer the following questions?

What is a healthcare system?

What is expected of it?

Do people have a moral right to government-funded healthcare?

How do we distribute limited healthcare resources fairly?

How did a Decent Minimum of Health Care (DMOHC) come about?

What is a DMOHC?

How does a DMOHC accommodate the six theories of distributive justice?

What is a healthcare system?

"A health system, also sometimes referred to as health care system or as healthcare system, is the organization of people, institutions, and resources that deliver health care services to meet the health needs of target populations." (Wikipedia 2017)

When I analyze this, I see three aspects:

1. There is the organization (an organizational structure is formed) of three things: People, institutions, and resources.
2. It has a function, namely to deliver health care services, thus it is a service delivery concept.
3. It is aimed at target populations, thus a particular system will not work for everyone in all places.

What is expected of it?

This is the most important question! A system's success will be judged by its ability to deliver on what is expected of it.

The World Health Organization (WHO): *"advises and assists countries to develop responsive and resilient health systems that are centered on people's needs and circumstances."* (World Health Organization 2017)

The WHO also define a well-functioning health system as such: *"A well-functioning health system working in harmony is built on having trained and motivated health workers, a well-maintained infrastructure, and a reliable supply of medicines and technologies, backed by adequate funding, strong health plans, and evidence-based policies. At the same time, because of the interconnectedness of our globalized world, health systems need to have the capacity to control and address global public health threats such as epidemic diseases and other events."* (World Health Organization 2017)

From these quotes, I would like to list the following (reasonable) expectations of a health system.

1. A healthcare system must be responsive to and centred around the community it service's circumstances and needs.
2. A healthcare system needs to be resilient in the face of crises, changes or resource constraints. The system must be able to cope and adapt to these challenges. The managers must be able to be innovative and dynamic within the parameters of the system.

3. A healthcare system must have trained and motivated health workers. Quality personal must be sourced and appointed and then there must be continues human resource development and a well-functioning employee wellness program.
4. A healthcare system must have a well-maintained infrastructure. With a sufficient maintenance budget and a good maintenance team.
5. A healthcare system must have a reliable supply of medicines and technologies. This will require a well-functioning administrative department and management team, with quality staff doing a good job at supply chain management.
6. A healthcare system must have adequate funding. There must be a good budgeting process, sufficient fund allocation, and a good financial management team.
7. A healthcare system must have a good management team, supported by evidence-based policies and strong health plans.
8. A healthcare system must be able to handle global public health threats. All systems are vulnerable to health crises from other countries and must have the capacity and ability to handle them.
9. A healthcare system must be a fair and just system. The system must be open to public and international scrutiny, before and after it is implemented. If any injustice occurs, the system must be able to change and adapt.

I would like to note that it is never mentioned that a health system must be comprehensive. The ability to decide what can and cannot be offered is paramount in the strategic planning of a health system.

Do people have a moral right to government-funded health care?

Beauchamp and Childress offer two arguments in support of the right to government-funded healthcare.

1. *"The argument from collective social protection"* (Beauchamp & Childress 2013:271):

Beauchamp and Childress argues that the government has an equal responsibility to meet the healthcare needs of a country, as they have the responsibility to meet the other needs, such as pollution, fire, education, and security.

A society may also expect a "decent return on the investment" from the contributions they make through taxation. These taxes are used to educate health care workers, for biomedical research and the establishment of the medical system of the country.

2. *"The argument from fair opportunity"* (Beauchamp & Childress 2013:271):

In this case Beauchamp and Childress asserts that social institutions should strive to correct the opportunities lost by persons, through events they could not control, due to misfortune that could not be predicted. Beauchamp & Childress put it as such: "Insofar as injuries, diseases, or disabilities create profound disadvantages and reduce agents' capacity to function properly, justice requires that we use societal health care resources to counter these effects and to give persons a fair chance to use their capacities."(Beauchamp & Childress 2017:272)

How do we distribute limited healthcare resources fairly?

The problem of how to distribute limited healthcare resources fairly is shared by all countries worldwide. The constant improvement in technological advances and increasing costs, combined with constant population growth and an increase in life expectancy, compound the problem.

The bioethical principle of justice deals specifically with this challenge. Justice is one of the four major principles in bioethics: Respect for autonomy, Nonmaleficence, Beneficence, and Justice. (Beauchamp & Childress 2013:13)

Justice is the equitable, fair and appropriate treating of people in line with what is owed and due to them. (Beauchamp & Childress 2013:250)

Moodley organize the different forms of justice according to their different obligations:

Legal justice: Respecting laws

Rights-based justice: Respecting people's rights

Distributive justice: The fair distribution of limited resources (Moodley 2017:91)

Beauchamp and Childress asserts that distributive justice is the equitable, fair and appropriate distribution of burdens and benefits according to the rules of a specific society. (Beauchamp & Childress 2013: 250) Moodley, Moosa, and Kling also hold that: *"The concept of justice as applied to the distribution of scarce resources is best defined in terms of fairness and desert (what one deserves, giving to each his or her due)."*(Moodley 2017:92)

At this point, it is important to note people have different opinions about what fair distribution of limited resources entails. This led to the development of various theories of distributive justice.

I will now analyze the six theories of distributive justice as discussed by Moodley and Beauchamp and Childress.

1.The Utilitarian theories

Moodley argues that utilitarians use the principle of utility to determine whether the standard of justice is sufficient. They want the overall positive impact of the healthcare resources, to be maximised. This would mean that they want the greatest number of people to receive the greatest amount of good. With regards to public health care, they want as many people as possible to have access to it. (Moodley 2017:92)

2.Libertarian theories

Moodley state that libertarianism supports a system in which individuals must pay for their own healthcare. They argue that you are only entitled to the health care that you pay for. This theory clearly supports the private health care system. (Moodley 2017:92)

3.Communitarian theories.

According to Moodley, people advocating this theory hold that the healthcare priorities of the community supersede those of the individual. The communities make decisions on what their healthcare needs are and how they will distribute the limited resources. (Moodley 2017:93)

Beauchamp and Childress argue that since there are multiple forms of communities, the communitarians regard principles of justice as pluralistic. They will use a variety of different conceptions of what is good, from all these different communities, to guide their principles of justice. (Beauchamp& Childress 2013:258)

4.Egalitarian theories.

According to Moodley egalitarianism propagates that, irrespective of whether a person can pay or not, the health care resources must be distributed equally, among all people. (Moodley 2017:93)

5.Capabilities theories.

Moodley reports that capabilities theories hold that for people to have a good quality of life, they need to be able to achieve certain things and to function well. Therefore people must be able to experience and sustain certain capabilities, such as life, bodily integrity, bodily health, imagination and thought, senses, emotions, affiliation, practical reason, living with other species, having control over their environment and having the ability to play. (Moodley: 2017:93)

6. Well-being theories.

Moodley mentions that well-being theories hold that, for justice to be achieved, there are six areas of well-being that should be at a sufficient level for all people, namely: personal security, health, respect, reasoning, self-determination, and attachment. (Moodley 2017:93)

When developing a healthcare system for a country one will seek to accommodate as many of the theories as possible. I will later reflect on how the healthcare system of South Africa accommodates these six theories of justice.

Moodley also mentions that in South Africa, distributive justice is especially relevant, since we have such limited resources in our public healthcare sector. (Moodley 2017:92)

How did a Decent Minimum of Health Care come about?

Beauchamp and Childress hold that *a "meaningful right of access to healthcare includes the right to obtain specific goods and services to which every entitled person has an equal claim."* (Beauchamp & Childress 2013:272) They further argue: *"A demanding interpretation of this right is that everyone everywhere has equal access to all goods and services available to anyone. Unless the world's economic systems are*

radically revised, this conception of a right is utopian. Rights to health-related resources will likely always have severe limits". " The right to a decent minimum of health care, therefore, presents a more attractive goal-and, realistically, probably the only goal that can be achieved. This moderate egalitarian goal is one of universal accessibility (at least in a political community) to fundamental health care and health-related resources." (Beauchamp & Childress 2013:272)

The idea of a DMOHC has evolved within the bioethical debate in the 20th century surrounding the question whether egalitarianism or liberalism is the appropriate approach to think about just/ethical healthcare provision.

Liberalism broadly argues that health care is a commodity that we are able to buy on the open market and that people should be left alone to provide it for themselves via mechanisms of the market.

Egalitarianism (e.g. Rawls) argues very differently: for them, health is a basic need that we require to function effectively as a species. Van Niekerk explains it as such: *"Healthcare refers to that category of needs necessary to reach our goals as members of our species, i.e. it belongs to that which is necessary to achieve, restore or maintain adequate ("species-typical") levels of functioning. Daniels's application of Rawls's theory, therefore, implies that each member of society, irrespective of*

wealth or position, must be, for the sake of justice as fairness, provided with equal access to adequate (though obviously, in the light of limits on resources, not maximal or the best available) levels of health care." (Van Niekerk, in Van Niekerk & Kopelman 2005:84-110)

Van Niekerk further contend that this implies that it is a different need than other needs that can be bought on the market and that society has some responsibility to fulfil that need.

That raises the question whether it is possible and desirable, both in principle and in practice, to provide all health needs. The answer is mostly that it is impossible to do that for two reasons. The one is that not all health needs are on par; open-heart surgery is much more vital and important for someone who needs it than e.g. cosmetic surgery; why should society pay for people's vanities? But the second, more important reason is that to provide in all needs is practically impossible because it is too expensive; choices need therefore to be made.

"Daniels, in his appropriation of Rawls's theory, shows that we have to work with a truncated scale of social goods. Arrangements are just when individuals are guaranteed a reasonable share of essential social goods." (Van Niekerk, in Van Niekerk & Kopelman 2005:84-110)

It is at this point that the possibility of a DMOHC comes to the fore: Yes, we can agree that health care is not a commodity; it is a more basic need. Yes, we can agree that it is in principle and in practice impossible to make provision for all needs. Is there not a midway? Is there not some decent minimum that society ought to provide without which we cannot go on, and which empowers people to, as far as possible, continue surviving as a species?

What is a DMOHC?

The standard conception of a DMOHC, according to Beauchamp and Childress, is a two-tiered system.

On tier one we find "*enforced social coverage*" of, and "*universal access*" (Beauchamp & Childress 2013:273) to Preventative care, acute care, primary care, public health protections, medical care for people with disabilities and medical care in case of a catastrophe.

On tier two are privately funded medical services. These are voluntary and meet both healthcare needs and desires, such as more luxurious hospital rooms, improved services, cosmetic surgery and cosmetic dental work. These services can either be paid for directly or covered by private healthcare insurance.

Therefore the term DMOHC, does not refer to the specific limit at which healthcare services are available in tier one, but it is a comprehensive term, used to describe the whole system, which includes the provision of a second tier to meet the needs of the libertarians.

Beauchamp and Childress argues that this type of healthcare system, therefore, mixes public and private forms of distribution. (Beauchamp & Childress 2013:273)

This definition is therefore only the standard conception as presented by Beauchamp and Childress and is not edged in stone. It can be adapted to be responsive to a country's circumstances and needs. Currently, a DMOHC as defined by Beauchamp and Childress resembles the healthcare system of South Africa, but in its current formulation it will not sufficiently meet the needs of South Africa and therefore I will, therefore, try to highlight its short-comings and recommend some changes, during the course of this paper.

Beauchamp & Childress does recognize some of the difficulties that may be faced with implementing such a system. Specifying and practically implementing the system will be difficult. They wonder whether it would be possible for a society to unambiguously, fairly and consistently create

a health care policy that acknowledges the right to primary healthcare, without creating a right to expensive and expansive forms of medical care. This challenge is probably faced by all countries and everyone needs to be able to set appropriate priorities when deciding how to distribute these scarce health resources. (Beauchamp & Childress 2013:273)

Beauchamp and Childress advises that fair and adequate public participation will be wise when deciding on the threshold for a decent minimum and in determining what goods and services must form part of the package's content and what would not be included. Procedures such as the setting of priorities, rationing, and allocation will have to form an integral part of the process and if there is disagreement about certain standards of health care, whether it is sufficient or decent, then there need to be fair processes to follow, to come to an agreement. In the end, the policy makers must be specific and precise about the composition of the package and communicate this information very well. (Beauchamp & Childress 2013:273)

How does a DMOHC accommodate the six theories of distributive justice?

Utilitarianism

With regard to a DMOHC, utilitarians would support such a system, since it strives for maximum social utility, minimizes dissatisfaction of the public and can make decisions regarding allocation according to cost-effectiveness analysis. (Beauchamp & Childress 2013:273) (Cost-effectiveness analysis "*...measures the benefits in non-monetary terms, such as years of life, quality-adjusted life years, or cases of disease.*") (Beauchamp & Childress 2013:231)

Having said this, one wonders if the utilitarians would support a health care system where only primary health care is possible due to the need of maximization of the public good? This implies that they themselves will not have access to specialized services.

Libertarianism

Beauchamp and Childress argue that, with regard to a DMOHC, the Libertarians will dislike the fact that they must pay for other people's health care and that the focus is on universal access and maximum utility in the first tier. But the second tier speaks to their heart and since this tier is open to private insurance and free choice, it opens the door for a free-market system for supplying of medical goods and services and for distribution of these goods. (Beauchamp & Childress 2013:273)

The libertarians must also accept the fact that they choose to live in a certain community, where they benefit from the mutual arrangements like

infrastructure (roads etc.), security and subsidized education and therefore they must also share in the social burdens, like providing health care to the poor.

Communitarianism

With regards to a DMOHC, communitarians will welcome the two-tiered system, since it accommodates the various socio-economic classes of the community while having a firm grip on the first tier, with regard to decision making about what is best for the community.

Egalitarianism

Beauchamp and Childress' view is that, with regard to a DMOHC, egalitarians support the equal access that all people will have to tier one and will rally for fair distribution of scarce resources in this tier.

(Beauchamp & Childress 2013:273) They will probably feel that all people must have access to the resources on tier two as well and they will probably continue to try to gain access to the resources on tier two.

Capabilities theories

With regard to a DMOHC, they support the efforts on tier one to improve all people's access to and quality of healthcare, and thereby improving their capabilities

Wellbeing theories

With regards to a DMOHC, the supporters of the wellbeing theory will support the efforts on tier one to promote healthy lifestyles, prevent diseases through vaccinations, to actively manage both acute and chronic illnesses and thus to improve all people's status of health and thereby improving their wellbeing. A DMOHC will also provide wellbeing with regards to respect since it respects the person as a valuable part of the society that must be cared for with regards to their health, so that they can continue to actively contribute to the society's well-being.

The health care system of a DMOHC seems to be able to accommodate all six theories on some level and therefore seems to be a fair approach to reforming health care systems.

To conclude this conceptual analyses I would like to analyze two of the concepts mentioned in the term Decent Minimum of Health Care: Decent and Minimum.

The word: "*Decent*" in a DMOHC:

The word decent is used to state that the amount of health care is enough and acceptable. Even if it is not always satisfactory, it is considered to be a just amount.

The word: "*Minimum*" in DMOHC:

The meaning of the word minimum according to the Cambridge

Dictionary is: "*The smallest amount or number allowed or possible.*"

(Cambridge Dictionary 2017)

This is a misnomer since what is actually set out in the content of tier one, of a DMOHC, is the absolute maximum that is possible within the budget allocated. The term minimum strikes me as "*second rate*" and can be construed as an insult as if you are only willing to give the minimum or see what is the minimum that one can get away with. Tier one should be described as: "*A just, efficient and effective, maximum level of health care possible within the allocated budget*".

Having concluded the conceptual analyses of a DMOHC, I now want to ask the following questions:

1. Why pick a DMOHC? Is it a good healthcare system in principle?
2. If so, why pick it for South Africa?

And lastly...

3. Is the current formulation of a DMOHC, still appropriate for current day South Africa? Or is there a need for some changes? And if so, what should those changes be?

1.3. Problem statement

South Africa is currently using a two-tier health care system, also known as a Decent Minimum of Health Care. In light of the challenges faced by our health care system, I ask the following questions:

1. Are these challenges due to external influences, such as the economy or politics?
2. Are they a result of simply too few resources being allocated to the health care system by the government?
3. Are they due to poor management of the healthcare resources and system?
4. Is the health care system chosen for South Africa not able to facilitate the service delivery expected of it? And if not, how should it be amended to achieve satisfactory results?

This last question is the focus of this thesis and I will specifically focus on solving the following three questions:

1.3.1. Problem 1: Is a DMOHC in principle a good idea?

1.3.2. Problem 2: Is a DMOHC a good idea for South Africa?

1.3.3. Problem 3: If so, what ought that decent minimum to be?

1.4. Structure of the thesis

Chapter one is the introduction and a reflection on the challenges faced by the South African health care system and the reason for this research. I do a conceptual analysis of what a health care system is and more specifically what is meant by a Decent Minimum of Health Care. I make a problem statement and set out the goals of this thesis. The introduction is then concluded by stating the structure that is followed during this thesis.

In chapter two, I give an explanation of the methods used in my research and for justification of the results.

In Chapter three I ask the question: Is a DMOHC in principle a good idea? I spend time arguing both in favor of it and against it and then summarize my findings with a resolution.

In chapter four, I follow the same process as in chapter four, but with the question: Is a DMOHC a good idea for South Africa?

In chapter five I address the question: If so, what ought that decent minimum to be? (This is in response to the finding of chapter four.) In my proposal I make three suggestions:

1. To prioritize health services in the public sector at a policy level.
2. To integrate the public and private health sectors through the NHI.
3. To increase both regulation and taxation of the private sector.

Although I argue in favor of and against all three of these suggestions, I focus on the first suggestion. I specifically focus on striving to justify this suggestion, as the main finding of this research. I end this chapter with my resolution.

Chapter six is my conclusion. In this chapter, I show that I have achieved what I have set out to do and summarize my resolutions regarding each of the three problems.

In Chapter seven I make suggestions based on the findings of this thesis and I remark on the way forward and propose ways to implement these suggestions.

The bibliography forms the last part of the thesis.

Chapter two

Methodology

In this thesis, I use the conceptual approach to research. I attempt to answer conceptual questions related to the health care system of South Africa, using the methods of both critical and creative reflection. I use critical reflection to analyze the current literature available on my topic. I dissect the various elements found in the literature and examine the relations among them. I then evaluate these results using specific norms and standards. I also use the process of creative reflection to construct new ideas and concepts and speculate regarding what changes to the healthcare system will constitute an improvement.

I start by doing a conceptual analysis of what is meant by a health care system and a decent minimum of health care system.

Three main questions are identified and presented in the problem statement. In attempting to answer them, I argue both for and against the proposed concepts. These arguments are made by critically reflecting on information gathered through literature reviews. The information is analyzed and then evaluated against relevant principles and values. At the

end of each deliberation process regarding a specific question, a conclusion is made.

In answering my third question: *"If so, what ought the decent minimum be?"* the method of creative reflection is also used to propose conceptual and more specific changes to the formulation of a DMOHC, currently in use in South Africa. These proposals are then analyzed and evaluated as was the case when answering the first two questions. At the end of this chapter, a conclusion is again made.

Chapter three

A DMOHC in principle

In chapter one, I have done a conceptual analysis of the two-tiered system known as a Decent Minimum of Health Care. I will now evaluate whether this system is a good system in principle. For this, I will look at arguments in favor of and against a DMOHC in principle.

3.1. Arguments in favor of a decent minimum in principle

3.1.1. Society has a moral obligation to correct inequalities which result from the social and natural lottery/specialty

If a child is born into a poor family, or the child is an orphan or disabled, then this is at no fault of its own and society has a moral obligation towards this child, to care for him or her (provide medical care, education, security, etc).

Anton Van Niekerk formulates Rawl's arguments as such:

"Rawl's basic assumption is that a social arrangement is a communal effort to advance the good of all members of society. Inequalities of birth, natural endowment, and historical circumstances are undeserved, and, in

a society where the co-operative nature of action to promote justice is taken seriously, every effort should be made to make more equal the unequal situation of people who have been disadvantaged by the mentioned factors." (Van Niekerk, in Van Niekerk & Kopelman 2005:84-110)

3.1.2. All people have "*a moral right to government-funded health care*"(Beauchamp & Childress 2013:271)

I present two arguments in support of this concept.

1. "*The argument from collective social protection*" (Beauchamp & Childress 2013:271):

Here Beauchamp and Childress argue that the government has an equal responsibility to meet the healthcare needs of a country, as they have the responsibility to meet the other needs, such as pollution, fire, education, and security.

A society may also expect a "decent return on the investment" from the contributions they make through taxation. These taxes are used to educate health care workers, for biomedical research and the establishment of the medical system of the country.

2. *"The argument from fair opportunity"*(Beauchamp & Childress 2013:271):

In this case Beauchamp and Childress asserts that social institutions should strive to correct the opportunities lost by persons, through events they could not control, due to misfortune that could not be predicted.

Beauchamp & Childress put it as such: *"Insofar as injuries, diseases, or disabilities create profound disadvantages and reduce agents' capacity to function properly, justice requires that we use societal health care resources to counter these effects and to give persons a fair chance to use their capacities."*(Beuachamp & Childress 2017:272)

3.1.3. A Decent Minimum of Health Care accommodates all six theories of justice.

I will now discuss the six theories of justice and show how they fit within a DMOHC.

Utilitarianism

Moodley reports that utilitarians use the principle of utility to determine whether the standard of justice is sufficient. They want the overall positive impact of the healthcare resources, to be maximised. This would

mean that they want the greatest number of people to receive the greatest amount of good. With regards to public health care, they want as many people as possible to have access to it. (Moodley 2017:92)

With regard to a DMOHC, Beauchamp and Childress argue that utilitarians would support such a system, since it strives for maximum social utility, minimizes dissatisfaction of the public and can make decisions regarding allocation according to cost-effectiveness analysis.

(Beauchamp & Childress 2013:273) (Cost-effectiveness analysis

"...measures the benefits in non-monetary terms, such as years of life, quality-adjusted life years, or cases of disease."(Beauchamp & Childress 2013:231)

Having said this, one wonders if the utilitarians would support a health care system where only primary health care is possible due to the need of maximization of the public good? This implies that they themselves will not have access to specialized services.

Libertarianism

Moodley argue that libertarianism supports a system in which individuals must pay for their own healthcare. They argue that you are only entitled

to the health care that you pay for. This theory clearly supports the private health care system. (Moodley 2017:92)

With regard to a DMOHC, Beauchamp and Childress' view is that the Libertarians will dislike the fact that they must pay for other people's health care and that the focus is on universal access and maximum utility in the first tier. But the second tier speaks to their heart and since this tier is open to private insurance and free choice, it opens the door for a free-market system for supplying of medical goods and services and for distribution of these goods. (Beauchamp & Childress 2013:273)

The libertarians must also accept the fact that they choose to live in a certain community, where they benefit from the mutual arrangements like infrastructure (roads etc.), security and subsidized education and therefore they must also share in the social burdens, like providing health care to the poor.

Communitarianism

Moodley argues that people advocating this theory hold that the healthcare priorities of the community supersede those of the individual.

The communities make decisions on what their healthcare needs are and how they will distribute the limited resources. (Moodley 2017:93)

Beauchamp and Childress also assert that there are multiple forms of communities, the communitarians regard principles of justice as pluralistic. They will use a variety of different conceptions of what is good, from all these different communities, to guide their principles of justice. (Beauchamp & Childress 2013:258)

With regards to a DMOHC, communitarians will welcome the two-tiered system, since it accommodates the various socio-economic classes of the community while having a firm grip on the first tier, with regard to decision making about what is best for the community.

Egalitarianism

Moodley assert that egalitarianism propagates that, irrespective of whether a person can pay or not, the health care resources must be distributed equally, among all people. (Moodley 2017:93)

With regard to a DMOHC, Beauchamp and Childress argues that, egalitarians support the equal access that all people will have to tier one and will rally for fair distribution of scarce resources in this tier.

(Beauchamp & Childress 2013:273) They will probably feel that all people must have access to the resources on tier two as well and they will probably continue to try to gain access to the resources on tier two.

There are two new theories of justice, that have been proposed in the 21st century:

Capabilities theories

Moodley assert that these theories hold that for people to have a good quality of life, they need to be able to achieve certain things and to function well. Therefore people must be able to experience and sustain certain capabilities, such as life, bodily integrity, bodily health, imagination and thought, senses, emotions, affiliation, practical reason, living with other species, having control over their environment and having the ability to play. (Moodley: 2017:93)

With regard to a DMOHC, they support the efforts on tier one to improve all people's access to and quality of healthcare and thereby improving their capabilities

Wellbeing theories

Moodley mentions that these theories hold that, for justice to be achieved, there are six areas of well-being that should be at a sufficient level for all people, namely: personal security, health, respect, reasoning, self-determination, and attachment. (Moodley 2017:93)

With regards to a DMOHC, the supporters of the wellbeing theory will support the efforts on tier one to promote healthy lifestyles, prevent diseases through vaccinations, to actively manage both acute and chronic illnesses and thus to improve all people's status of health and thereby improving their wellbeing. A DMOHC will also provide wellbeing with regards to respect since it respects the person as a valuable part of the society that must be cared for with regards to their health so that they can continue to actively contribute to the society's well-being.

The health care system of a DMOHC seems to be able to accommodate all six theories on some level and therefore seems to be a fair approach to reforming health care systems.

3.1.4. International movement towards a DMOHC system/Two-tiered system

According to Ter Meulen , we find that in European, solidarity and not justice guides health and social policies. In the European welfare states, it is assumed of everyone to make fair financial contributions to a collective organized insurance system. This insurance system will then guarantee equal access to social and health care for all the members of society. But the modern patient is a much more well-informed and critical consumer, who wants value for their money. There is also decreasing support for people who behave irresponsibly due to unhealthy lifestyles. In the Netherlands, there seems to be a decrease in the support of the solidarity system and a move towards a two-tier system of health care, where they introduced in 2006, market-based competition, and the Dutch can now make private payments and arrange private health insurance, that compliments the basic health care insurance. (Ter Meulen 2011:615)

3.1.5. The money spent in tier two is justified

The amount of money spend in tier two can far exceed the money spent in tier one. Anton Van Niekerk notes that, in South Africa, 60% of the total amount of money spent on health care, is spent in the private sector,

which makes up, less than 20% of the country's population. While in the public sector, the government is spending 40%, of the total amount of money spent on healthcare, on 80% of the country's population. This obviously draws most of the health care professionals to the private sector and affects the care of patients in the public sector. Is this fair/just? (Van Niekerk 2002:37)

Fenton reports, that according to Allen Buchanan, allowing people to spend their money the way they deem fit, is very important. This is an essential part of having liberty and not allowing people to buy extra health care will be an unacceptable interference with the individual's liberty and will undermine the justice of the system. (Fenton 2015:127)

Secondly, no one wants to spend more money on health care. They are forced to, due to the adverse conditions of the public healthcare sector. The "*poor*" people that have already paid for the public health care services, through taxes must now fork out more money, just to receive good health care. (Regarding the "*poor*" people: Note, that most of the people who have medical aids, are not abundantly rich, but ordinary people scraping together every penny they have, to feel safe when they are sick.)

What is unfair, is not getting anything back for the money you spend, because of unacceptably poor levels of health care. It is also unfair to blame the people spending money in tier two for the low amount spent by the government in tier one. The poor economic growth of the country, the poor tax revenue allocation decisions and the poor health care management decisions are all the fault of the government and not the fault of the tax paying citizens "*forced*" by poor health care services on tier one, to pay extra to access health care services on tier two.

So to conclude, it is perfectly just for people to spend any amount they want in tier two and the only thing unfair is the government's poor contribution and management of tier one.

3.2. Arguments against the idea of a decent minimum in principle

3.2.1. The difficulty of providing "*Universal access*" (Beauchamp & Childress 2013:273) to the healthcare system

The concept of "*universal access*" requires consideration. It essentially means that we need to be able to provide a decent minimum of health care to all the people in our country. If our population growth exceeds our economic growth, then the simple fact is that it will become increasingly

more difficult to render the healthcare services the government promises to the people. To be precise, it means, that we have to decrease the healthcare services we make available on an annual basis.

What one also needs to realize is that there is an increasing number of illegal immigrants also being serviced in our public health care system. This exacerbates the problem.

3.2.2. A DMOHC does not ensure adequacy

Fenton raises the interesting point of adequacy. A health care system might be just and decent, but what if it remains inadequate?

The main question would be: What content will be construed as adequate? This will also probably differ from one social community to another. (Fenton 2015:129)

An attempt has been made to answer this question. Lawrence Schroederman proposed the following: *"...a decent minimal level of health care would be whatever is required 'to enable a person to acquire an education, seek or hold a job, or raise a family.' Or, if a person is unable to achieve those goals, to obtain 'a reasonable level of functioning within the person's limits and respectful of the person's*

dignity, as well as a reasonable level of comfort.' (Paris 2016:6) John Paris does not seem impressed with this attempt and believes it is doomed to fail. (Paris 2016:16)

This remains a valid question and worthy of further research. It will probably have to be determined through consultation with the community, for whom the system is designed, and it will probably have to vary from one social community to another, to accommodate the differences in values. One community, for example, may put a higher value on dental care or the aesthetics of a person's teeth, where for another community the availability of arthroplasty surgery (joint replacements) will be more important.

3.2.3. The risk of a widening gap between tier one and two

There is an increasing gap between the rich and the poor of the world, especially in developing countries. If a country's economy does not allow opportunities for hard-working citizens to attain a better quality of life, the fact that there is a second tier of health care services becomes irrelevant, since it is unattainable.

For us to separate the two groups' health care in such a "*clinical*" manner is to say that as long as I pay my taxes I can forget about the poor's health care. If there is improved medical technology in tier two, that could potentially save people who are dying in tier one, surely the policymakers have to look into ways to make it available to them. If tier two is the locomotive, then tier one is the carriage and we must always prevent the carriage from falling behind. I believe it is this widening gap that has led to the establishment of the National Health Insurance (NHI). The NHI is a desperate attempt by the government to close the gap between tier one and tier two.

3.3. Conclusion

In the light of these arguments, I conclude that a DMOHC is in principle a good system that will accommodate most people. However, there remains a responsibility on the policymakers to ensure that the healthcare services offered on tier one are adequate and remain, in some way, in touch with the services offered on tier two.

Chapter four

A DMOHC for South Africa?

South Africa is currently using the two-tiered health care system known as a Decent Minimum of Health Care. Even though I have established that it is in principle a good system, the question remains whether or not it is a good system for South Africa.

4.1. Arguments in favor of a DMOHC for South Africa

4.1.1. The poor socio-economic status of the majority of South Africans

According to Van Niekerk, around 80% of South Africans are reliant on the public health sector for health services. (Van Niekerk 2002:37)

Benatar asserts that the division of the health services provided for the rich and those provided for the poor has been a long time coming and is a global phenomenon: *"With the introduction of financial deregulation, privatisation and liberalisation of global trade in the late 1970s, the general trend in global health followed two diverging paths. One pursued boosted economic growth and the application of medical advances for the*

benefit of the top 20% of the global population (about 1 billion people), living predominantly in wealthy countries. The other was characterized by impediments to economic growth for a poor majority, deterioration in their living conditions and curtailment of public health services."

(Benatar 2013:154-155)

Benatar then goes further by elaborating on the situation in South Africa:

"In South Africa, apartheid sustained and amplified the effects of both of these pathways. Since 1994, praiseworthy changes have been made in healthcare legislation and practice, and in the living conditions of many. However, continuation of free-market policies, inadequate economic growth, rapid urbanization, migration, corruption, and poor management of public services by the new government have caused disparities to widen. Most South Africans remain severely impoverished, despite social grants, with inferior access to healthcare (excepting HIV/AIDS care)."

(Benatar 2013:154-155)

Therefore since the majority of the South African population are too poor to pay for medical services, the South African government has a moral obligation to provide health care services to them, through a DMOHC system.

4.1.2. The weak South African economy

Our country's economy is too weak to support a pure libertarian approach to health care. The majority of the people will simply find it virtually impossible to overcome poverty, of which these two indicators testify:

"GDP Growth Rate in South Africa averaged 2.90 percent from 1993 until 2016" (Trading Economics 2017) and

From 1968 to 2017 the South African inflation rate averaged 9.19% per year. In the first quarter of 2017, the inflation rate was between 6.6% and 6.1%. (Trading Economics 2017)

This means that our economic growth does not exceed out inflation rate.

Our country is becoming poorer and poorer. Furthermore, in the last quarter of 2016 and the first quarter of 2017, the South African economy has experienced negative growth, consequently, we have recently been in a recession.

If our country can not drastically improve its economic growth rate, we will see an ever-increasing demand on the public healthcare sector, as more and more people will start to struggle financially and become unable to afford private health care.

4.1.3. *The "apartheid" legacy*

During the time of "*apartheid*" regime, people of color did not have an equal opportunity to become wealthy enough to afford medical aids. The economic inequality brought about by "*apartheid*" has unfortunately not been rectified and the generations that have followed are still not able to afford medical aid. Therefore the government must still provide healthcare services on tier one, to the previously disadvantaged people.

Also, as mentioned before, the South African government, during the apartheid era, focused mainly on providing tertiary, curative care to the white minority who held the political and economic power. When the World Health Organization introduced the Health For All (HFA) principles and advocated the Primary Health Care (PHC) approach, which was desperately needed among the black community, the government of the time did not show much interest. This, unfortunately, led to many unnecessary deaths, due to curable diseases, simply due to the lack of sufficient primary health care. (Gilbert & Gilbert 2003)

Unfortunately, this legacy is still present and there is a lot of room for improvement in the delivery of healthcare, especially at primary health care level. One of the main problems is the lack of healthcare infrastructure in the rural areas. Unfortunately, people have to travel vast

distances to access healthcare facilities. This causes time delays between the onset of illness and the delivery of medical care that could prove to be fatal. The apartheid legacy has therefore left service delivery gaps which need to be rectified on tier one.

4.1.4. South Africa must adopt a health care system that aligns itself with international healthcare movements and goals

Gilbert and Gilbert report that a 'global' health policy originated in the late '70s and early '80s when the World Health Organization introduced the Health For All (HFA) principles. These principles suggested that the health of a country's citizens is the responsibility of the government. One of the important concepts conveyed by these principles is that equity in the distribution of healthcare is very important, both within and between different countries. The principles also recognize that there are multiple determinants of health, such as economic, lifestyle, social and environmental factors. These principles amongst other similar principles led to the emergence of the Primary Health Care (OHC) approach. This approach advocated early, holistic, preventative care and the importance of promoting health, rather than focussing on curative medicine, which was more expensive. (Gilbert & Gilbert 2003)

Furthermore, following the Millennium Summit of the United Nations which took place in 2000, eight international development goals (called the Millennium Development Goals) were established for the year 2015. All of the 189 United Nations member states at the time and at least 22 international organizations, committed themselves to help achieve these goals. South Africa was among these nations. The MDGs were:

- "1. To eradicate extreme poverty and hunger.*
- 2. To achieve universal primary education.*
- 3. To promote gender equality and empower women.*
- 4. To reduce child mortality.*
- 5. To improve maternal health.*
- 6. To combat HIV/Aids, malaria, and other diseases.*
- 7. To ensure environmental sustainability.*
- 8. To develop a global partnership for development." (Wikipedia 2017)*

4.2. Arguments against a DMOHC for South Africa

4.2.1. The widening gap between public and private healthcare

The gap between the public and private health sector has widened to the extent that it seems impossible to bridge the gap. Benatar states that:

"..., with annual per capita health care expenditure as disparate as \$150 (R1 200) in the public sector serving 84% of the population, and \$1 500 (R12 000) in the private sector for 16% of the population, achieving equity for individuals at levels close to those current in the private sector would require more human and material resources than is possible."

(Benatar 2013: 154-155)

This happened, because the private sector continues to improve their level of care, by bettering their facilities, acquiring the latest equipment, expanding on the diversity of the services they offer and subsequently raising the prices for the services they deliver. They are also financially or profit-driven enterprises. In other words, they want to make profits and will always be looking at ways to make more profit. They will also focus their service delivery efforts on endeavors that will make the most profit for their company.

On the other hand, the funds available to the public healthcare sector are, unfortunately, decreasing in relative terms and therefore the gap will continue to widen.

Benatar summarises it as such:

"Globally, privileged people have understandably become less aware of the social determinants of health, and their focus has shifted to an expensive bio-medical technological approach to health. Healthcare, especially in the USA, has increasingly become a marketable commodity

within a so-called free-market system, where everything is calculated, planned and delivered within an economic and regimented managerial mindset. Endless expectations and increased orientation towards patients as clients have changed the concept of health care from a caring, social function, provided through universal access as a social duty to all citizens of equal moral worth, to a profit-driven commercial enterprise run by a medical care industry in the private sector, and a poorly managed, cost-containment exercise in an overwhelmed public sector. In both these contexts, health care professionalism tends to be eroded."

(Benatar 2013: 154-155)

The DMOHC does not address this widening gap. The system needs to be adapted to allow for a way to keep the service delivery on the two tiers in touch with each other. An example of this has been the regulations imposed in South Africa, which fixed the profit margins for the sale of medication, which undoubtedly made medical care more cost effective and affordable.

4.2.2. The increase in mortality due to non-communicable diseases shows that people do not take responsibility for their lifestyles

In 2015 Statistics South Africa released a detailed report on causes of death. In that year 460, 236 deaths were recorded. This indicated a 3.0% decline in deaths processed from 2014 to 2015, in comparison to the 474

659 deaths from 2013 to 2014. The top three leading causes of natural deaths during 2014 and 2015 were tuberculosis, diabetes mellitus, and cerebrovascular diseases. (South African Government 2017) (Statssa 2017) See table below for the top 10 causes of death.

Causes of death (based on ICD-10)	2013			2014			2015		
	Rank	Number	%	Rank	Number	%	Rank	Number	%
Tuberculosis (A15-A19)**	1	41 904	8,8	1	39 495	8,3	1	33 063	7,2
Diabetes mellitus (E10-E14)	5	23 133	4,9	3	23 966	5,0	2	25 070	5,4
Cerebrovascular diseases (I60-I69)	4	23 158	4,9	2	24 131	5,1	3	22 879	5,0
Other forms of heart disease (I30-I52)	6	22 189	4,7	4	22 928	4,8	4	22 215	4,8
Human immunodeficiency virus [HIV] disease (B20- B24)	3	23 825	5,0	6	22 729	4,8	5	21 926	4,8
Influenza and pneumonia (J09-J18)	2	24 345	5,1	5	22 813	4,8	6	20 570	4,5
Hypertensive diseases (I10-I15)	7	17 104	3,6	7	18 319	3,9	7	19 443	4,2
Other viral diseases (B25-B34)	9	14 101	3,0	9	14 508	3,1	8	16 097	3,5
Chronic lower respiratory diseases (J40-J47)	10	12 384	2,6	10	12 690	2,7	9	12 667	2,8
Ischaemic heart diseases (I20-I25)	...	...	...		...	...	10	12 239	2,7
Intestinal infectious diseases (A00-A09)	8	16 163	3,4	8	14 795	3,1	...	...	...
Other natural causes		207 523	43,6		207 593	43,7		202 840	44,1
Non-natural causes		49 681	10,4		50 692	10,7		51 227	11,1
All causes		475 510	100,0		474 659	100,0		460 236	100,0

"The ten leading underlying natural causes of death, 2013–2015" (Statssa 2017)

An important matter to note is the continued rise of non-communicable diseases (diseases that are not passed on from one person to another) in the top ten leading causes of death. Diabetes mellitus moved from third to second from 2014 to 2015. In fact, non-communicable diseases formed no less than 60% of the top ten leading natural causes of death in South Africa. *"In addition to diabetes mellitus; cerebrovascular diseases, other forms of heart disease, hypertensive diseases, chronic lower respiratory diseases and ischaemic heart diseases contributed to the rise in non-communicable diseases."* (South African Government 2017)

These figures show that there is an increase in people who are not living healthy lifestyles in South Africa. Because they are unhealthy they contribute less to the economy and consume more healthcare resources. It is unfair that people who choose healthy lifestyles and work hard must pay for other people's poor choices.

4.2.3. Tier one is overexposed to political influence

There is a risk that the health care services on tier one are exposed to political influences, which might have an adverse effect on health care provision.

A case in point was President Thabo Mbeki and the Minister of health Dr. Manto Tshabalala-Msimang who did not accept that HIV caused AIDS, even though the official government policy of South Africa said otherwise. (South African History Online 2016)

The fact that political leadership, opposed the official government policy, is very worrying and ask the question: Is the health care system overexposed to political influence? Should evidence-based medicine be allowed to be overridden by politicians?

4.3. Conclusion

A DMOHC is in principle a good health care system for South Africa, but in its current configuration, it is doomed to fail. This is because the revenue available for funding the public healthcare sector is decreasing annually in relative terms. The gap between the public and private sector is ever widening, especially due to the financially driven private sector and the impossibility of the average poor person to gain access to the private health care system, due to the poor economy of the country. Therefore we cannot accept the current formulation of a DMOHC. We have to be innovative and introduce change.

Chapter five

A Proposal for a DMOHC system for South Africa

I have now concluded that a DMOHC is in principle a good health care system for South Africa, but I have also discovered three problems:

1. The healthcare resources (more specifically, the revenue) available to the public healthcare sector are decreasing annually in relative terms.
2. South Africa's poor economy makes it virtually impossible for the average poor person, to work themselves out of poverty and gain access to the private health care system.
3. The financially driven private sector keeps on escalating the cost of healthcare.

In light of these problems: What ought a DMOHC to look like for South Africa?

How should the system be adjusted to address these three problems?

There are three fundamental changes that need to be made to the health care system of South Africa:

1. Strategic planning for utilizing the depleting health care resources.

2. Integration of the public and private healthcare sector.

3. Innovation in regulating and taxing the private sector.

5.1. Proposal of this thesis

I will now specify the three changes I propose to the current DMOHC system currently in place in South Africa.

5.1.1. Change one: Prioritize and ration health care services at policy level

In the current healthcare setting in South Africa, there are a lot of prioritizing and rationing going on, but not all these processes are done according to official protocols. A lot of prioritizing and rationing are done at the bedside of patients, by inexperienced junior doctors. This is unfair towards these doctors and their decisions are not necessarily evidence-based. These necessary cost savings are directly linked to the fact that the country's revenue is decreasing annually in relative terms and the need for them will most probably increase. In order to prevent mistakes in the allocation of scarce resources, which can lead to even bigger shortages, we must prepare now, by drafting contingency plans and guiding protocols that are backed by legislation.

These policies must have very specific plans of action regarding the processes that need to be followed and very specific guidelines which are all backed by various evaluation processes including quantitative analysis and scrutiny by healthcare management boards and ethical committees.

In the end, it must be backed by legislation, which will protect the healthcare practitioner at an operational level.

I would like to give two examples of this proposed change:

Example one: "*Oregon's Experiment with Prioritizing Public Health Care Services*" (Perry et. al 2011:241-247)

Perry et. Al reports that such a system is being used, in Oregon (USA) as a kind of running experiment, since 1990, when they introduced a prioritized list of health services that would be covered by the Oregon Health Plan (OHP). This was a first of its kind in the world. (Perry et. al 2011:241-247)

Perry et al. states that the state of Oregon aimed to provide basic health care services to as many people as possible and they wanted to define a

"*basic*" level of healthcare through a public process. This was one of the key areas where they were different. In the past decisions on prioritizing were made by administrators and clinical personnel, but they opted for a public and transparent process. (Perry et. al 2011:241-247)

Perry et. Al further mentions that a Health Services Commission was created. They were a panel of experts, comprising eleven people: Four consumer members, five physicians, a social worker and a public health nurse. This panel had to develop the ranked prioritized list. The list was ranked from "*the most important to cover*" healthcare procedures, at the top of the list, to "*the least important to cover*" healthcare procedures, at the bottom of the list. It would then be handed over to the legislatures "*to 'draw the line' at covered and uncovered services.*" This literally meant drawing a line "*on a piece of paper*" (on a computer screen), and thereby splitting the list of healthcare procedures into two sections. Healthcare procedures above the line would be covered and therefore available to patients and healthcare procedures below the line, would not be covered and therefore would not be available to patients. (Perry et. al 2011:241-247)

Perry et. Al also states that there were much more people who worked on the list and cost-benefit formulae such as an early form of quality-

adjusted life years were used. The analytic approaches did not provide all the answers and the panel had to move certain items on their own judgments of common-sense. (Perry et. al 2011:241-247)

Perry et. Al reports that the list is reviewed twice a year and due to budget constraints and recommendations by the Health Services Commission, the legislature has moved line between uncovered and covered items, several times since the list's inception. This literally meant that the line was moved up or down on the list, thereby either including less covered healthcare procedures, when moved up, or more covered healthcare procedures, when moved down. (Perry et. al 2011:241-247)

Example two: "... a basic moral and public-policy commitment to non-abandonment:" (Landman & Henley 2000:43)

This is another example of prioritizing and rationing at a policy level, although it will form part of a more specified policy.

Landman and Henley explain it as follows:

"as far as possible, on a macro level, no category of vital health-care need, including highly specialized or costly health-care, should be excluded from (some) public funding. To this end, rationing, we suggest, should be done according to the following non-abandonment formula.

For each highly specialized or costly category of health-care need, for example, cystic fibrosis (CF), leukemia, and paediatric kidney transplantation, determine the unit cost (the cost of standard medical treatment per child per year), multiply that rand amount by the number of children in each category of vital need, and then sum all these totals. Express the total available health-care budget for highly specialized or costly health-care for children for a particular year as a percentage of that sum, and fund each speciality according to that percentage. The approximate number of children each specialty will be able to treat is determined by dividing its allotted rand amount by its unit cost."

(Landman & Henley 2000:41)

This method is in some ways the opposite of the prioritized list of health care services, but I am confident that it will be possible to integrate various such methods into one policy. In the case of these two examples, one can allocate a budget for primary health care services prioritized by the prioritized list and a separate allotted amount for specialized services rationed using the non-abandonment policy.

There are two additional concepts I would like to add to this proposed change: 1. The importance of public participation:

The public should be informed of the allocation processes proposed and consulted to understand their preferences and get their inputs. The

education process regarding what can and should be expected of the health care system must be a thorough one.

2. The importance of supportive and palliative care:

We need to have strong support systems in place for people who cannot get treatment for their specific illnesses. This should apply to life-limiting illnesses and non-life-limiting illnesses. Protocols for supportive care, for conditions such as osteoarthritis, for example, should be put into place, in the absence of readily available joint replacement surgery.

In the case of life-limiting illnesses, the field of palliative care will be of the utmost importance. *"Palliative care is a multidisciplinary approach to specialized medical care for people with life-limiting illnesses. It focuses on providing people with relief from the symptoms, pain, physical stress, and mental stress of the terminal diagnosis. The goal of such therapy is to improve quality of life for both the person and their family."* (Wikipedia 2017)

The way we manage the dying patient will be more important, than whether we necessarily attempt to cure the patient. People should not be left feeling abandoned and as if they have to cope with their illness alone.

5.1.2. Change two: Integration of the public and private healthcare sector, by utilizing the National Health Insurance (NHI)

Although I do not support change two, I have to include it, because the NHI is due for imminent implementation and therefore must be included in this paper dealing with the healthcare system of South Africa.

The NHI will facilitate the integration of the public and private healthcare sectors. The truth is that this method only provides a way for the poor to gain access to private health care services.

A positive goal will be for the patients on medical aid, who are currently making use of the private healthcare sector, to also access the public healthcare facilities. They might use the public healthcare services for primary health care, and only use their medical aid for specialized healthcare services. They should not pay for these services though but access these services for free. They already pay for them through their tax contributions. Utilizing these services will decrease their financial burden and might make them more willing to contribute to the NHI. But for this proposal to be realistic, there must be a vast improvement in service delivery in the public healthcare sector. I do not wish to discuss the changes that are needed to facilitate this, other than saying that in my view, for the most part, and in most cases, the poor service delivery is due

to managerial inadequacies. I do wish to elaborate on the proposed NHI and the methods of funding it and the way forward.

The NHI policy document has been approved by parliament and was published in the Government Gazette on 30 June 2017. I will now quote the definition and features of the NHI as stated in the policy document:

"2.1 Definition

National Health Insurance is a health financing system that is designed to pool funds and actively purchase services with these funds to provide universal access to quality, affordable personal health services for all South Africans based on their health needs, irrespective of their socio-economic status. NHI will be implemented through the creation of a single fund that is publicly financed and publicly administered. The health services covered by NHI will be provided free at the point of care. NHI will provide a mechanism for improving cross-subsidization in the overall health system. NHI benefits will be in line with an individual's need for health care. Implementation of NHI is based on the need to address structural imbalances in the health system and to reduce the burden of disease.

2.2 Features of NHI

NHI will have the following features:

- a) Progressive universalism: All South Africans will have access to needed promotive, preventive, curative, rehabilitative and palliative health services that are of sufficient quality and are affordable, without exposing them to financial hardships. The right to access quality health services will be based on need and not socioeconomic status. NHI will seek to protect the poor and vulnerable populations to ensure that they gain as much as those who are better off at every step of implementation, in pursuit of moving towards UHC.*
- b) Mandatory prepayment of health care: NHI will be financed through mandatory prepayment which is distinct from other modes of payment such as voluntary prepayment and out-of-pocket payments.*
- c) Comprehensive Services: NHI will cover a comprehensive set of health services that will provide a continuum of care from community outreach, health promotion, and prevention to other types and levels of care.*
- d) Financial risk protection: NHI will ensure that individuals and households do not suffer financial hardship and/or are not deterred from accessing and utilizing needed health services. It involves eliminating*

various forms of direct payments, such as user charges, co-payments, and other direct out-of-pocket payments.

e) Single Fund: NHI will integrate all sources of funding into a unified health financing pool that caters for the needs of the population.

f) Strategic purchaser: NHI will purchase services for all; and will be an entity that actively utilizes its power as a single purchaser to proactively identify population health needs and determine the most appropriate, efficient and effective mechanisms for drawing on existing healthcare service providers.

g) Single-payer: NHI will be structured as an entity that pays for all health care costs on behalf of the population. A single-payer contract for healthcare services from providers. Single-payer refers to the funding mechanism and not the type of provider.

h) Publicly Administered: NHI will be established as a single fund that is publicly administered and publicly owned. It will be responsible for pooling and purchasing of health services through appropriate structures that are responsible for contracting accredited providers on behalf of the entire population. The aim is to introduce an administratively efficient

and sustainable funding mechanism that achieves the best value-for-money with respect to health budget allocations." (Government Gazette 2017:8-9)

Funding of the NHI will essentially be through additional taxation.

I have attached the *"Options for public funding of NHI"* (Government Gazette 2017:44) as Annexure 2.

A newspaper article in *"Die Burger"* (Eastern Cape) of 30 June 2017 called: *"Medies: Jy word dalk so gemelk"* by Nellie Brand-Jonker, discussed the way forward.

According to Brand-Jonker, Dr. Aaron Motsoaledi, the minister of health, told the media during a media conference on 29 June 2017, that the process will now be started to get the NHI-law through parliament. At least 12 laws will have to be amended. One of which is the law on medical schemes. (Brand-Jonker 2017:1)

In the first phase, that lasted up to this point, the policy was developed.

In the next phase, that will last until 2022, the focus will be on legislation, the development and consolidation of medical aids to offer additional coverage and current tax credits for medical aid members will be taken away (the current tax deductions available for medical aid contributions, will no longer be allowed) and poured into the NHI fund. In the last phase

from 2022-2026, the compulsory contributions to the NHI will start.

(Brand-Jonker 2017:1)

The money in the NHI fund will be used to purchase health care services from the private sector, but the prices that a hospital or specialist can charge will be regulated. Dr. Motsoaledi said that once the NHI is established, medical aids such as Gems, Polmed and Parmed (all of which cover various government departments) will be unnecessary. (Brand-Jonker 2017:1)

Personally, I question the methods of funding the NHI, the lofty goals set out and the risk of dependency on the private sector. I deal with these three issues in my arguments against this proposed change. I also wonder why the government does not use the funds they raise for the NHI to improve their own facilities and render the services, they now want to purchase from the private sector, themselves?

5.1.3. Change three: Innovations in regulating and taxing the private sector

Regarding innovative changes to regulation

Jonathan Broomberg, CEO of Discovery Health, has suggested the following reforms to the private sector:

He suggests empowering the medical aids to regulate medical expenditures in the private sector. This will decrease the cost of private health care. I do not support this idea since the medical aids are also for-profit organizations and it would be a conflict of interest to give them the power to control expenditures in the private sector. If they decrease the expenditures they will also be decreasing their payouts, which would be to their benefit.

Although I do not support empowering medical aids, I do support the following suggestion by Broomberg:

"Fundamentally, the private healthcare system is structurally incentivized towards over-servicing, through the predominant fee-for-service reimbursement mechanism.

Regulatory reforms allowing hospitals or other entities to employ doctors (currently prevented by legislation) would improve efficiencies, allowing the emergence of efficient, integrated healthcare care teams, as can be found in the mining industry.

Encouragement of hospital reimbursement models based on single payments for clinically similar cases can be encouraged as these actively incentivize providers to avoid unnecessary services." (Broomberg 2011)

I strongly support the suggestion of private hospitals employing doctors. This will drive costs down significantly. Private specialists often charge

much more than medical aid rates and patients need to pay co-payments for some procedures. If the specialists were to work for a salary, this will not happen. I also suggest that the hospitals cover the cost of medical insurance for their employees, which will eliminate the doctor's motivation to charge excessive fees.

The second part of his suggestion regarding "*single payments for clinical similar cases*" (Broomberg 2011), can only be done if the hospital employs the doctor. In this case, the medical aid pays a specific amount for the procedure and all costs for the hospital, equipment, and the doctor's fee come from that amount. The current suggestion is that since the doctor does not work for the hospital, the medical aid pays the amount over to the hospital, they first deduct their costs and what is left, gets paid to the doctor. This is not a favorable situation for the doctor since he can not guarantee the recovery speed of the patient and therefore the time spent in the hospital can deplete the doctor's fee.

The main point to take out of this suggestion is that we should be innovative in how we regulate the private sector.

I would like to make two specific suggestion regarding regulatory changes:

1. Adjust regulation that inhibits cost-effective health care, such as allowing hospitals to employ doctors working in their facilities, to only mention one example.
2. I also suggest the regulation of all medical fees across the board. This means fixed rates for consultations, procedures, prices of equipment and medication.

In essence, I suggest the demise of the free market system, when it comes to health care in South Africa. I do not mean the death of the private sector. Healthcare businesses in the private sector will be able to see as many or as little patients as they wish and control their income. They will be able to create first world environments and provide up to date medical care. They will just not be able to charge what they want for it. The onus rests on the government to make sure that there is a big enough profit margin to still promote the delivery of private first world health care services.

Regarding taxation

I suggest a super tax for all health-related businesses. By health-related businesses, I mean any business that makes a profit from any health-

related service or product. Hospitals, private clinics, private general practitioners, pharmacies, medical insurance companies, health shops, paramedical service providers, absolutely everyone.

I suggest standardized salaries to be determined, using similar trades in the public sector as a reference. If none is available, then suggested salaries should be determined. All these businesses should firstly use their revenue to allow for the payment of these salaries. Therefore the proposed supertax, should not affect the employee's livelihood. The supertax will only affect the shareholder's return on investment.

Thereafter all profits made by these businesses, up to 15% of investment amount (Thus, up to profit of 15% Return on investment (ROI); ROI as a percentage is the nett income divided by the investment amount, and multiplied by one hundred), will be taxed as per the current tax sliding scale.

The supertax will only apply to profits made over and above 15%. These "excessive" profits will be aggressively taxed according to a sliding scale. With aggressive I mean up to from 50% to 80% of these profits, using a sliding scale. If the business, for instance, made a profit of say 20% ROI, they will pay normal tax on the first 15%, but then a super tax on the additional 5% of say 50-60%. If they made 25% ROI profit they will pay

normal tax on the first 15% ROI, then on the next 5% they will pay 50-60% tax and on the last 5% say 60-70% tax, and so on. There is therefore still ample opportunity for this business to make a very reasonable profit and the supertax will only affect profits above 15% ROI. They will therefore still have a good reason for existence and they will even have the ability to make as much profit as they want to, they will just have to share more of it with others and I believe the incentive to be financially and profit-driven will decrease. They might opt for a business model that is more quality driven and affordable to patients, so to ensure sustainability even in economically tougher times. It will curtail the incentive to make excessive profits and there should be no benefit in running a skeleton crew. Therefore this will also lead to job creation and better service delivery.

All these additional taxes should not go towards the normal tax revenue collected by SARS. These funds should go directly into the NHI account and should only be used for the NHI purposes. The NHI will use the funds to purchase services from the private sector and therefore these "excessive" profits will be plowed back into the same private sector out of which it is taken.

Why did I pick 15%?

The banking industry considers 15% ROI as a general goal and when I reference this with a search on the internet it was confirmed by an article by Susan Schreter:

"Because entrepreneurs typically pull their savings from the stock or bond market, comparing public market index returns is a helpful exercise. Most investors define success as beating the S&P 500, which returned about 15 percent in 2010. This should be your minimum expectation of investment success." (Schreter 2011)

Thus 15% will still equate to investment success and will make these businesses still financially viable. Of course, it must be said that they still have the opportunity to make profits in excess of 15%, they will just pay more tax and take home less.

To summarise, I believe that this supertax will be the best way to fund the NHI. The NHI can then use these funds to purchase healthcare services for public patients, from the private healthcare sector. This will then narrow the gap in service delivery between tier one and tier two of a DMOHC.

5.2. Arguments in favor of proposed changes

5.2.1. The utilitarian argument in favor of all three changes

According to Moodley, the utilitarian theory of justice wants the greatest number of people to receive the greatest amount of good. (Moodley 2017:92) All three the proposed changes aim to achieve this goal.

Change one: Prioritize and ration health care services at policy level, aims to achieve the maximum benefit from the resources available.

Change two: Integration of the public and private healthcare sector, by utilizing the National Health Insurance (NHI), will result in uplifting the public healthcare sector by improving their access to various healthcare services.

Change three: Innovations in regulating and taxing the private sector, aims at optimize access to health care services through decreasing costs and increasing the availability of funds.

Arguments in favor of change one: Prioritize and ration health care services at policy level

5.2.2. A Deontological argument in favor of prioritizing and rationing at policy level

According to Beauchamp and Childress the Deontological or nonconsequentialist theory holds that actions are right or wrong due to reasons other than consequences or reasons in addition to consequences. (Beauchamp & Childress 2013:361) The theory is also called Kantianism since Immanuel Kant (1728-1804) was instrumental in establishing much of the theory's current formulations. (Beauchamp & Childress 2013:361) Kant believes that morality is grounded in reason and since people are rational beings, they should prescribe moral rules to themselves that will guide their actions. (Beauchamp & Childress 2013:362) The theory has two cornerstone concepts:

- 1) We as people have the ability to reason and create "*non-contradictory and universal principles*" (Coffey & Brown 2015:69)
- 2) "*our freedom to agree to do our duty*". (Coffey & Brown 2015:69)

Even if resources are in abundance, it is good managerial practice to prioritize and ration the resources available to ensure that it will be used optimally and responsibly. It is simply the right thing to do, even if doing it has no direct consequence. Even if the resources are unlimited, we should always treat it with respect.

5.2.3. The principle of beneficence support prioritizing and rationing at policy level

Beneficence is the main principle that comes into play with this proposed change.

According to Beauchamp and Childress the principle of Beneficence holds that we should:

Prevent harm and evil

Remove harm and evil and

Promote and do good. (Beauchamp & Childress 2013:152)

Beauchamp and Childress further states that there are two types of beneficence:

Positive beneficence, where we do something good for the patient and

Utility, where we balance risks, costs, and benefits and try to get the best overall result. (Beauchamp & Childress 2013:202)

Regarding positive beneficence:

Beauchamp and Childress mentions that there is no clear line between the ideal beneficence (extreme altruism and severe sacrifice) and obligatory beneficence. The common morality certainly does not require us to hurt

ourselves or our families to help others, but there are some prima facie rules of obligation that the principle of positive beneficence supports:

(Beauchamp & Childress 2013:204)

"1. Protect and defend the rights of others.

2. Prevent harm from occurring to others.

3. Remove conditions that will cause harm to others.

4. Help persons with disabilities.

5. Rescue persons in danger." (Beauchamp & Childress 2013:204)

The first two points are specifically relevant to this proposed change.

During times of resource crisis, we have to stand up for the rights of everyone, especially the vulnerable and we have to prevent harm by preventing mistakes in allocating scarce resources and the subsequent shortages it will entail.

Regarding utility, the second form of beneficence:

Beauchamp and Childress argues that here the benefits are assessed, relative to the risks and costs. (Beauchamp & Childress 2013:229)

They further mention that quantitative analytic techniques are used, such as Cost-benefit analysis, which measures the benefits and costs in monetary terms and Cost-effectiveness analysis "*...measures the benefits in non-monetary terms, such as years of life, quality-adjusted life years,*

or cases of disease."(Beauchamp & Childress 2013:231)(Beauchamp & Childress 2013:230)

They also mention that risks can be identified, estimated and evaluated, and *these "are all stages in risk assessment."*(Beauchamp & Childress 2013:232) Risks can also be evaluated, relative to the probable benefits, and this is called risk-benefit analysis. Risks can also be assessed by comparing the magnitude and probability of the harm. After all of this, the risk must be managed and controlled through, for instance, policies created by management.(Beauchamp & Childress 2013:232)

Utility is also a key element in this proposed change. If utility as a form of beneficence is seen as a good thing, it strongly supports the proposed change of prioritizing at a policy level.

Arguments in favor of change two: Integration of the public and private healthcare sector, by utilizing the National Health Insurance (NHI)

5.2.4. Change two facilitates access to private, first world health care, for the poor

The NHI will bridge the gap between the public and private sector. It allows the poor access to first world health care, which would not be possible otherwise. The NHI also serves as a safety net for the public sector, allowing them the ability to buy health care services in times of crisis. For example, if a public hospital's CT scan breaks down, they might access the private sector's CT services.

Arguments in favor of change three: Innovations in regulating and taxing the private sector

5.2.5. Curtailment of the rise in private health care costs

By regulating prices of both goods and services in the healthcare sector, the rise in private health care costs will be curtailed. This will allow much more people access to private healthcare and it will narrow the gap between the public and private healthcare sector.

5.2.6. Innovative funding of the NHI

The super tax charged on excessive profit margins will be an innovative way to fund the NHI. This will also allow the government to allow the current members of medical aids to keep their tax credits, which help

them to afford their health care insurance. The money generated from this super tax, will also be used, to buy health services from the very people who paid the tax, thus reinvesting in the private sector.

These two arguments in favor of change three do not justify the proposed changes at all. They simply reflect the reasoning behind the suggestion. I consider justifying such proposed changes a too lofty goal for this paper and I consider these suggestions as a mere starting point for future discourse, as food for thought.

5.3. Arguments against the proposed changes

Arguments against change one: Prioritize and ration health care services at policy level

5.3.1. Prioritizing and rationing of health care services at policy level is overly paternalistic

According to Beauchamp and Childress, paternalism is defined as: "*...the intentional overriding of one person's preferences or actions by another person, where the person who overrides justifies this action by appeal to the goal of benefiting or of preventing or mitigating harm to the person*

whose preferences or actions are overridden."(Beauchamp & Childress 2013:215)

Beauchamp and Childress further mentions that paternalistic behaviour is common in medical practice and is a necessity at times. The conflict with respect for autonomy is recognized and therefore this behaviour needs to be clearly justified. (Beauchamp & Childress 2013:214)

This proposed change is a form of hard paternalism (when autonomous, voluntary and informed actions and choices get overridden). (Beauchamp & Childress 2013:216) Unfortunately, not all people will agree with the prioritizing and rationing policies and they will rightly feel that their choices of how tax money should be spent on health care and which services should be provided to them are not recognized.

5.3.2. Decisions made by "*Prioritizing committees*" could be overly utilitarian

This point was raised regarding the Commission involved with the prioritized list of health care services in Oregon. *"Robert Veatch worried that the physician-dominated Health Services Commission would err on the side of strict utilitarianism."* (Perry et. al 2011:241-247) It will

probably be much easier to justify decisions made on utilitarian arguments and using analytic approaches, but this will unfortunately not always provide the correct answers. An example of this is found in Perry et. Al's article regarding the prioritized list of health care services in Oregon: *"The initial list, based on a methodology of cost-benefit analysis yielded some peculiarities, such as possibly covering tooth caps, but not surgery for emergent appendicitis;"* (Perry et. al 2011:241-247)

5.3.3. Will the public understand the logic of prioritizing and rationing policies?

Or will they blow cases of non-treatment out of proportion?

In the case of the prioritized list of health care services in Oregon, Perry et. Al mentioned the following: *"In a free society, news coverage will focus on rationing decisions because of the human drama. In Oregon, media certainly played a role in forming public opinion, perhaps prolonging the superheated rhetoric. For this reason alone, one group of health scholars actually advocated physician-based bedside rationing, rather than public rationing in the U.S., with its acrimonious debate in the news and in state assemblies."* (Perry et. al 2011:241-247)

If the public does not have clear insight into why there needs to be rationing and prioritizing at policy level and if they do not actively take part in creating the policy and if they do not support the policies wholeheartedly, then there is a risk that in cases where specific curative treatment is not available, there may be uprising, against the system.

Arguments against change two: Integration of the public and private healthcare sector, by utilizing the National Health Insurance (NHI)

5.3.4. The public sector may become dependent on the private sector

The purchasing of certain health care services from the private sector may lead to the public sector neglecting their own facilities, which are currently providing these services. It might even get to the point where the public sector becomes reliant solely on the private sector for these specific services. They might decide to discontinue offering certain service within the public sector and solely purchase these services from the private healthcare sector. This will enslave the public sector to the private sector. Even if they did not want to continue purchasing these services from the private sector, they will have no choice, but to continue, because the infrastructure, equipment, manpower, and expertise will simply not be available within the public healthcare sector anymore and

they might not have the funds to re-establish these services within the public healthcare sector.

I am therefore worried about the strategic thinking regarding the NHI and wonder why the government could not use the NHI money to simply provide the identified services themselves?

5.3.5. An additional tax burden

To fund the NHI the government will instigate additional taxation of the private sector. This will aggravate a lot of people who are already struggling in the current poor economic environment.

The first proposed way of funding the NHI is the cancelation of the current tax rebate on medical aid contribution. This will have an immediate effect on the disposable income of the public.

I will now quote various sections from the Annexure discussing "Options for public funding of NHI" (Government Gazette 2017:44-47)

It lists the various proposed ways to fund the NHI through additional taxation and it elaborates on the pros and cons. In this section I will only add the possible negative impacts.

Payroll taxes

"Payroll taxes are sometimes used as mandatory membership contributions and can be significant revenue sources. Payroll-based social security taxes usually take the form of a fixed rate of tax on earnings, levied on employees or employers, or both. An earnings ceiling may be prescribed, at which the tax is capped in nominal terms, but this results in these taxes becoming regressive." (Government Gazette 2017:44-47)

"However, it does not draw revenue from high-income individuals who are not necessarily 'employed' (e.g. those whose income is from inherited wealth, investments, etc.) and may have a negative impact on formal sector employment creation, especially for entry-level jobs." (Government Gazette 2017:44-47)

Surcharge on taxable income

"A surcharge on taxable personal income is a further option for financing NHI. The current personal income tax structure is progressive, beginning with a marginal tax rate of 18 per cent and increasing to a maximum marginal rate of 40 per cent – raised to 45 per cent with effect from the 2017/18 tax year." (Government Gazette 2017:44-47)

"A higher overall personal income tax burden would impact on the disposable income of households and could be phased in with due regard to its impact on consumption expenditure and economic activity."

(Government Gazette 2017:44-47)

Value-Added Tax

"From a tax efficiency perspective, there are several arguments for favoring an increase in value-added tax. The present value-added tax rate of 14 per cent is moderate by comparison with the international average (16.4 per cent) and its base is broad, reaching both the formal and informal economies." (Government Gazette 2017:44-47)

"However, from an equity perspective, there is concern that value-added tax is regressive. To some extent, this is offset by zero-rating basic necessities, though this relief probably benefits middle and higher income earners more than the poor (because of their higher absolute levels of spending), and some of the benefit goes to suppliers rather than benefiting consumers through lower prices." (Government Gazette 2017:44-47)

Duties on alcohol and tobacco

"There is an obvious appeal in the idea that duties on alcohol and tobacco products should contribute to financing health services, as their consumption adds substantially to the burden of disease and injury. This is a route that some countries have followed, though it is unrealistic to expect a major share of financing to come from these taxes. There are two main drawbacks. Firstly, high rates of tax on alcohol and tobacco products lead to an increase in illicit trade (resulting, for example, in higher consumption of tobacco products that are neither taxed nor subject to health regulations). Secondly, the revenue-raising potential is insufficient relative to the quantum of health financing required." (Government Gazette 2017:44-47)

Excises or duties on other non-essential goods and services, and taxes on wealth or property

"Excises or duties on other non-essential goods and services, and taxes on wealth or property are sometimes proposed as options for health service funding. The securities transfer tax (STT), currently payable at a rate of 0.25 percent, contributed R 5.5 billion to the fiscus in 2015/16. The Estate Duty is a form of wealth tax, which yielded R2 billion in 2015/16."

"While these are possible revenue sources, there are no clear reasons why they should be dedicated to health expenditure rather than general revenue. In respect of their revenue collecting potential, these options have little to offer by comparison with taxes on income and consumption. Furthermore, it is impractical to base health financing arrangements on taxes that are intrinsically unreliable or volatile as sources of finance, or costly to collect." (Government Gazette 2017:44-47)

Carbon tax

"In exploring NHI financing options, consideration might also be given to the implications of the carbon tax proposed as part of South Africa's efforts to mitigate the effects of climate change. During the first phase, the proposed carbon tax regime, which will allow a minimum tax-free threshold of 60 percent, is projected to generate over R8 billion per annum. It is not intended to increase the overall tax burden, and offsetting measures to address adverse impacts on low-income households and industry competitiveness will be introduced. Depending on the exact quantum of tax revenues raised and the amount of such tax revenues that will remain after funding various revenue recycling initiatives, there may be scope to reduce other taxes."

"However, this should not be seen as a tax base that will continue to expand indefinitely. The primary objective of the carbon tax is to encourage a change in behavior through the pricing of an externality, and the ideal is to see an eventual decline in the carbon intensity of the economy that should ultimately lead to a decrease in associated tax revenues over time." (Government Gazette 2017:44-47)

In my opinion, these proposed ways of funding the NHI through additional taxes will have a negative impact on economic growth and foreign investment. This is because foreign investors want a hospitable environment to invest in. Environments where they can make optimal profits. High taxes, threatens the profitability of companies and will therefore scare off foreign investment.

5.3.6. Pursuing too lofty goals

If the NHI leads to the abolishment of government subsidized medical aids such as Gems and Polmed, it might expose the public servants to great risks of insufficient health care coverage. It is natural to assume that the money in the NHI will be distributed equitably across the previously insured (under Polmed for instance) and the previously uninsured. If

these funds are then too little to cover the previously insured adequately, it may be a disaster.

Arguments against change three: Innovations in regulating and taxing the private sector

5.3.7. The end of the free market system in the healthcare sector

What is a free market system?

"One view is that a free market is a system in which the prices for goods and services are determined by the open market and consumers, in which the laws and forces of supply and demand are free from any intervention by a government, price-setting monopoly, or other authority." (Wikipedia 2017)

The third proposed change can certainly be seen as killing the free market section of the South African healthcare industry. This will also mean less foreign investment in South Africa, which will have severe consequences. The negative impact this change will have on the South African economy might also lead to job losses and a decrease in tax revenue for the country. In the end, you might have fewer resources for the public healthcare sector and more people dependant on it.

As a counter-argument to the above mentioned, I want to ask this: How free do we consider the current South African economy and more specifically the private healthcare sector?

As it stands the profit margins on the sale of medication is already regulated.

I would also like to share the following sections out of an article by Mike Schussler regarding the South African economic system:

"Today, South Africa is a social-market economy at best with a nominally free-market system with limited government intervention in price formation. But the state provides significant services in the area of social security, unemployment benefits and recognition of labor rights through national collective bargaining arrangements." (Schussler 2014)

"South Africa is the only country that has more people on social security than are actually paying taxes. Over 20% work for the state, while State-owned enterprises (SOEs) and agencies take that percentage close to 25%.

Therefore nearly 40% of the population is dependent on the state for at least part of their income. This number is far higher than even some so-called Northern European welfare states. The state also provides not just

health and education but housing and most services to the home along with some subsidized transport." (Schussler 2014)

"The state owns much of South Africa via agencies and state companies South Africa also has over 500 SOEs across a spectrum of sectors from electricity to mining, from airlines to telecommunications, as well as many state agencies which provide transport, roads, and licenses.

So a good case can be made for the big role the state plays in the corporate sector. In SA the state competes against other taxpayers and then uses taxes to help out those industries, such as airlines and mining, that cannot compete against the tax-paying competition.

Here the state also plays a limited, but meaningful role in the pricing of goods and services that people use daily, indicating a rather more socialist market type of economy." (Schussler 2014)

"So what should one then call the type of economy that South Africa has? I would say that if the social market economy is there to fix market 'mistakes' then in South Africa's case there is much market fixing of state failures. So perhaps we are the world's first marketwise socialist state.

We have one of the broadest ownership models as well as a very high percentage of the population on social welfare – certainly this would confuse the best policy guru.

So economic identity and policy confusion reign and the liberation and new slogans don't match reality.

That much is clear. The rest has the transparency of mud." (Schussler 2014)

From Schussler's argument, I want to take the following. The South African government is currently influencing the economy directly by using taxes to support SOEs, who then compete against tax-paying companies. The government is already playing a meaningful role in the pricing of goods and services that we use daily. Thus if the government start regulating the pricing of healthcare goods and services, more aggressively, we can certainly not say it is a new phenomenon in South Africa. But whether this is a good road to take is uncertain. It seems like these interventions are coming about more out of necessity to cover a poor economic policy than as the consequence of a sound long-term strategic economic plan. I am of the opinion that an economic policy that encourages foreign investment, local production and exports will result in economic growth, that will make these interventions unnecessary. But since this not the topic of this paper, I will not expand on it further.

5.4. Conclusion

The first suggested change to the health care system seem in order with strong arguments in favor thereof. The potential risks in making this change are too small not to strongly consider it. With regards to the

second change I do understand why the government decided on implementing the NHI, but I do not support this change mainly due to adverse effect I believe the additional taxation will have on the South African economy and due to the fact that I do not believe the lofty goals of the NHI are possible to achieve. With regard to the third change, we must be cautious. The suggestion to adjust certain regulations such as the employment of medical doctors by private hospitals is a seemingly good idea, but the aggressive regulation of prices for goods and services and the adding of a super tax might be over ambitious and too risky.

Chapter six

Final conclusion

It was proven that Prof. Benatar's view *"of the need for new values beyond those perpetuated by prevailing market rhetoric and current ideology."* (Benatar 2013: 154-155) is certainly justified. The challenges faced by the South African healthcare system support this argument, with one of the major concerns being the fact that the revenue available for health care services is decreasing annually in relative terms, due to poor economic growth and high inflation. This problem is compounded by the impact of malpractice litigation. On the other hand, the gap between the public and private healthcare sector is widening, as is economic inequalities between the rich and the poor.

Amidst all of these challenges, it is vital for South Africa to have an effective and efficient health care system and good governance to manage it. Although good management is of paramount importance, the focus of this paper was to evaluate the current South African health care system, which is a two-tiered system, known as a Decent Minimum of Health Care. This type of healthcare system mixes public and private forms of distribution. (Beauchamp & Childress 2013:273) It must be said that I consider the "Minimum" to be a misnomer since what is actually set out

in the content of tier one, is the absolute maximum that is possible within the allocated budget. Tier one should be described as: *"A just, efficient and effective, maximum level of health care possible within the allocated budget"*.

After evaluating a DMOHC system, I found it to be a good system in principle, which will accommodate most people, since:

1. Society has a moral obligation to correct inequalities due to the social and natural lottery.
2. All people have *"a moral right to government-funded health care"*(Beauchamp & Childress 2013:271
3. A Decent Minimum of Health Care accommodates all six theories of justice.
4. There is an international movement towards a DMOHC system/Two-tiered system.
5. The money spent in tier two is justified.

Although, there are the following concerns:

1. The difficulty of providing "Universal access" (Beauchamp & Childress 2013:273) to the healthcare system.
2. A DMOHC does not ensure adequacy.
3. The risk of a widening gap between tier one and two.

Therefore, there remains a responsibility on the government (policy makers) to ensure that the healthcare services offered on tier one are adequate and remains, in some way, in touch with the services offered on tier two.

I also find a DMOHC to be a good idea for South Africa, because of the following arguments:

1. The poor socio-economic status of the majority of South Africans.

Where it was found that since the majority of the South African population are too poor to pay for medical services, the South African government has a moral obligation to provide health care services to them, through a DMOHC system.

2. The weak South African economy makes it increasingly more difficult for people to work themselves out of poverty and pay for medical services.

3. The "apartheid" legacy.

Unfortunately, this legacy is still present and there is a lot of room for improvement in the delivery of healthcare, especially at primary health care level.

4. South Africa must adopt a health care system that aligns itself with international healthcare movements and goals.

There are also arguments against a DMOHC system for South Africa, which are:

1. The widening gap between public and private healthcare.
2. The increase in mortality due to non-communicable diseases show that people are not taking responsibly for their lifestyles.
3. Tier one is over-exposed to political influence.

Despite these arguments, a DMOHC remains, a good health care system for South Africa, but in its current configuration, it is doomed to fail. This is because the revenue available for funding the public healthcare sector is decreasing annually in relative terms, the gap between the public and private sector is ever widening, especially due to the financially driven private sector and the impossibility of the average poor person to gain access to the private health care system, due to the poor economy of the country. Therefore we cannot accept the current formulation of a DMOHC. We have to be innovative and introduce change.

Thus, although a DMOHC is in principle a good health care system and a good health care system for South Africa, three problems were discovered:

1. The healthcare resources (more specifically, the revenue) available to the public healthcare sector are decreasing annually in relative terms.

2. South Africa's poor economy, makes it virtually impossible for the average poor person, to work themselves out of poverty and gain access to the private health care system.
3. The financially driven private sector keeps on driving up the cost of healthcare.

In light of these problems, three changes to the health care system of South Africa is proposed:

1. Prioritize and ration health care services at a policy level.
Due consideration must also be given to the importance of public participation and the importance of supportive and palliative care.
2. Integration of the public and private healthcare sector, by utilizing the National Health Insurance (NHI).
3. Innovations in regulating and taxing the private sector.

Two specific suggestions regarding regulatory changes are made:

1. Adjust regulation that inhibits cost-effective health care, such as allowing hospitals to employ doctors working in their facilities, to only mention one example.
2. I also suggest the regulation of all medical fees across the board. This means fixed rates for consultations, procedures, pricess of equipment and medication.

Regarding taxation, the following specific suggestion is made:

I suggest a super tax for all health-related businesses. By health-related businesses, I mean any business that makes a profit from any health-related service or product. Hospitals, private clinics, private general practitioners, pharmacies, medical insurance companies, health shops, paramedical service providers, absolutely everyone.

I suggest standardized salaries to be determined, using similar trades in the public sector as a reference. If none is available, then suggested salaries should be determined. All these businesses should firstly use their revenue to allow for the payment of these salaries. Therefore the proposed supertax, should not affect the employee's livelihood. The supertax will only affect the shareholder's return on investment.

Thereafter all profits made by these businesses, up to 15% of investment amount (Thus, up to profit of 15% Return on investment (ROI); ROI as a percentage is the nett income divided by the investment amount, and multiplied by one hundred), will be taxed as per the current tax sliding scale.

The supertax will only apply to profits made over and above 15%. These "excessive" profits will be aggressively taxed according to a sliding scale.

With aggressive I mean up to from 50% to 80% of these profits, using a sliding scale. If the business, for instance, made a profit of say 20% ROI, they will pay normal tax on the first 15%, but then a super tax on the additional 5% of say 50-60%. If they made 25% ROI profit they will pay normal tax on the first 15% ROI, then on the next 5% they will pay 50-60% tax and on the last 5% say 60-70% tax, and so on. There is therefore still ample opportunity for this business to make a very reasonable profit and the supertax will only affect profits above 15% ROI. They will therefore still have a good reason for existence and they will even have the ability to make as much profit as they want to, they will just have to share more of it with others and I believe the incentive to be financially and profit-driven will decrease. They might opt for a business model that is more quality driven and affordable to patients, so to ensure sustainability even in economically tougher times. It will curtail the incentive to make excessive profits and there should be no benefit in running a skeleton crew. Therefore this will also lead to job creation and better service delivery.

All these additional taxes should not go towards the normal tax revenue collected by SARS. These funds should go directly into the NHI account and should only be used for the NHI purposes. The NHI will use the funds to purchase services from the private sector and therefore these

"*excessive*" profits will be plowed back into the same private sector out of which it is taken.

I believe that this supertax will be the best way to fund the NHI. The NHI can then use these funds to purchase healthcare services for public patients, from the private healthcare sector. This will then narrow the gap in service delivery between tier one and tier two of a DMOHC.

Arguments in favor and against all three these proposals were analyzed. The first proposed change of prioritization and rationing of health care services at policy level was supported by both a utilitarian argument and a deontological argument and it was further supported by the principle of beneficence. With the arguments against change one being, that prioritizing and rationing of health care services at policy level are overly paternalistic, decisions made by "*Prioritizing committees*" could be overly utilitarian and the uncertainty whether the public will understand the logic of prioritizing and rationing policies or blow cases of non-treatment out of proportion? In conclusion, the first suggested change to the health care system seem in order with strong arguments in favor thereof. The potential risk in making this change is too small not to strongly consider it.

With regards to change two, the integration of the public and private healthcare sector, by utilizing the National Health Insurance (NHI), the utilitarian argument and the facilitation of access to private, first world healthcare, for the poor, both supported this change. The arguments against change two, where Arguments against change two, where the risk of the public sector becoming dependent on the private sector, the possible negative impact that the additional tax burden might have on the South African economy and the seemingly unrealistic goals set out for the NHI. With regards to this change I do understand why the government decided on implementing the NHI, but I do not support this change mainly due to adverse effect I believe the additional taxation will have on the South African economy and due to the fact that I do not believe the lofty goals of the NHI are possible to achieve.

With regards to change three, innovative regulating and taxing of the private sector, the utilitarian argument, curtailment of the rise in private healthcare costs and the innovative way of funding the NHI, all supported this change. The argument against this change was the devastating effect it will have on the free market system in the private healthcare sector. Thus with regard to the third change, we must be cautious. The suggestion to adjust certain regulations such as the employment of medical doctors by private hospitals is a seemingly good idea, but the

aggressive regulation of prices for goods and services and the adding of a super tax might be over ambitious and too risky.

In conclusion, then, a DMOHC in principle is a good healthcare system and a good system for South Africa. Like all things, change is constant and I strongly support prioritizing and rationing health care services at a policy level. The NHI will probably soon be supported with legislation and its implementation is imminent. Whether its proposed structure will be a success, is uncertain and I am highly skeptical of its lofty goals and the effects of additional taxation on the South African economy. I do not suggest the implementation of my third change, although I do think a super tax on excessive profits made by health-related businesses is more palatable than additional taxes on the general community.

Chapter seven

Recommendations

I would only like to make recommendations regarding my first proposed change, namely: We must prioritize and ration health care services at a policy level.

I propose that a risk assessment is done by health economists regarding the ability of the department of health to sustain current service delivery. Based on the findings of this report, I propose two things.

On the one hand, the government can implement innovative methods of increasing the revenue available for funding the department of health and thus the delivery of healthcare services. This will no doubt include the NHI, which will probably serve as a tool in sustaining and hopefully improving health care service delivery.

On the other hand, I propose the establishment of a health care services prioritization and rationing committee for South Africa. This committee should create policy documents governing prioritization and rationing of healthcare services in all settings and at all levels and these policies should be backed by legislation.

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Annexure

"Options for public funding of NHI" (Government Gazette 2017:44)

"7.5 Options for public funding of NHI"

225. There are several options for raising revenue to fund NHI and the funding will be through a combination of various sources. The three main sources of general tax revenue in South Africa are personal income tax, value-added tax, and corporate income tax. These three tax instruments accounted for 80.3 percent of total tax revenues in 2011/12.

7.5.1 Payroll taxes

226. Payroll taxes are sometimes used as mandatory membership contributions and can be significant revenue sources. Payroll-based social security taxes usually take the form of a fixed rate of tax on earnings, levied on employees or employers, or both. An earnings ceiling may be prescribed, at which the tax is capped in nominal terms, but this results in these taxes becoming regressive.

227. A payroll tax has potential as a further extension of the South African tax structure: the present payroll tax burden is low, it would be a buoyant and stable source of revenue and it would be administratively straightforward and health is one amongst several social benefits that

could be financed in this way. It is administratively feasible as it will be based on an existing administrative framework and will require minimal changes to the existing tax administration system. However, it does not draw revenue from high-income individuals who are not necessarily 'employed' (e.g. those whose income is from inherited wealth, investments, etc.) and may have a negative impact on formal sector employment creation, especially for entry-level jobs.

7.5.2 Surcharge on taxable income

228. A surcharge on taxable personal income is a further option for financing NHI. The current personal income tax structure is progressive, beginning with a marginal tax rate of 18 percent and increasing to a maximum marginal rate of 40 percent – raised to 45 percent with effect from the 2017/18 tax year. Taxable income is calculated as gross income minus allowable deductions (including business expenses and contributions to retirement funds). Gross income includes income from employment and capital income (interest and profits in the case of unincorporated businesses). A personal income tax surcharge would be administratively feasible in South Africa as it would be based on a well-established system.

229. *A higher overall personal income tax burden would impact on the disposable income of households and could be phased in with due regard to its impact on consumption expenditure and economic activity.*

230. *Australia introduced a surcharge on taxable income, known as the Medicare Levy when the Medicare program was started in 1984. It is a supplement to other tax revenue which enables the government to meet the additional cost of providing a prescribed set of health benefits for the whole population, whereas the previous system was limited to subsidies for healthcare to groups with low incomes. However, the general tax revenue remains as the main source of funding for publicly funded health services in Australia.*

7.5.3 Value-Added Tax

231. *From a tax efficiency perspective, there are several arguments for favoring an increase in value-added tax. The present value-added tax rate of 14 percent is moderate by comparison with the international average (16.4 percent) and its base is broad, reaching both the formal and informal economies. Value-added tax is robust (buoyant) in that it generates a substantial and stable share of national income in tax revenue. Consumption taxes are generally considered less distortionary in their impact on the productive allocation of resources, they do not*

impact negatively on formal sector employment and they do not discourage savings, which is important for economic growth.

232. However, from an equity perspective, there is concern that value-added tax is regressive. To some extent, this is offset by zero-rating basic necessities, though this relief probably benefits middle and higher income earners more than the poor (because of their higher absolute levels of spending), and some of the benefit goes to suppliers rather than benefiting consumers through lower prices.

7.5.4 Other possible tax instruments

233. While taxes on consumption and income are the main available sources of revenue, there are various other taxes and levies that could contribute to financing NHI.

234. There is an obvious appeal in the idea that duties on alcohol and tobacco products should contribute to financing health services, as their consumption adds substantially to the burden of disease and injury. This is a route that some countries have followed, though it is unrealistic to expect a major share of financing to come from these taxes. There are two main drawbacks. Firstly, high rates of tax on alcohol and tobacco products lead to an increase in illicit trade

(resulting, for example, in higher consumption of tobacco products that are neither taxed nor subject to health regulations). Secondly, the revenue-raising potential is insufficient relative to the quantum of health financing required.

235. For the 2015/16 tax year, about R17.3 billion in revenue was raised from cigarette sales and R21.7 billion from taxes on alcohol sales. Even substantially higher rates of tax would not yield sufficient revenue to meet long-term health financing needs, in part because of the loss to illicit trade and in part because these products make up a small and possibly declining share of overall consumption. Excises or duties on other non-essential goods and services, and taxes on wealth or property are sometimes proposed as options for health service funding. The securities transfer tax (STT), currently payable at a rate of 0.25 percent, contributed R 5.5 billion to the fiscus in 2015/16. The Estate Duty is a form of wealth tax, which yielded R2 billion in 2015/16.

236. While these are possible revenue sources, there are no clear reasons why they should be dedicated to health expenditure rather than general revenue. In respect of their revenue collecting potential, these options have little to offer by comparison with taxes on income and consumption.

Furthermore, it is impractical to base health financing arrangements on taxes that are intrinsically unreliable or volatile as sources of finance, or costly to collect.

237. In exploring NHI financing options, consideration might also be given to the implications of the carbon tax proposed as part of South Africa's efforts to mitigate the effects of climate change. During the first phase, the proposed carbon tax regime, which will allow a minimum tax-free threshold of 60 percent, is projected to generate over R8 billion per annum. It is not intended to increase the overall tax burden, and offsetting measures to address adverse impacts on low-income households and industry competitiveness will be introduced. Depending on the exact quantum of tax revenues raised and the amount of such tax revenues that will remain after funding various revenue recycling initiatives, there may be scope to reduce other taxes.

238. This might be viewed as a suitable way of contributing to NHI for two reasons. Firstly, the carbon tax can be linked to health concerns through adverse impacts on the environment and quality of life associated with climate change. Secondly, the revenue-raising potential is higher than the other taxes explored and could possibly increase in subsequent phases (from 2020) as the tax-free thresholds are

progressively decreased. However, this should not be seen as a tax base that will continue to expand indefinitely. The primary objective of the carbon tax is to encourage a change in behaviour through the pricing of an externality, and the ideal is to see an eventual decline in the carbon intensity of the economy that should ultimately lead to a decrease in associated tax revenues over time." (Government Gazette 2017:44-47)