NHI musn't just be about the money – Daily Maverick 15 October 2019

The NHI debate cannot be dominated by 'financing of health' language: the absence of human rights principles and safeguards can easily translate into sectors of our population being left behind in healthcare.

The long-awaited and thorough Health Market Inquiry (HMI) report paints an alarming picture of private healthcare. The report indicates that private healthcare in South Africa is characterised by high and rising costs, significant over-utilisation, no documented measures for health outcomes, highly concentrated facilities and administrators, and medical schemes that are not sufficiently accountable to members.

The performance of public health is also beset with numerous challenges and the 2018 Auditor-General's report indicates that more than 50% of health facilities are near collapse and require immediate intervention. Drivers of system dysfunctionality include poor capacity and resource constraints, shortages of health facilities and human resources practitioners and specialists, governance issues and corruption, and runaway medical-legal costs.

These prolonged and systemic failures in our health systems are affecting equitable access to healthcare, with infringements on our right to health. It also means that the pathway towards an integrated and functional health system is a challenge of enormous magnitude.

While the HMI report makes some far-reaching recommendations to rectify regulatory failings in private healthcare, an equally compelling feature is the analytical tone of the report; it presents a well-considered and thoughtful approach, supported by an evidence-based analysis of market failures on both the funder and provider sides of the system. The report serves as a vital signpost for how we should structure conversations on health reform.

At a broader level, international efforts to meet goals of universal health coverage within the sustainable development goals (SDG) framework is also prompting a shift in approach. Both the public health and the human rights paradigms — and the systems of thought and action that flow from them — are rapidly evolving.

The challenge of applying a social determinants understanding to health (recent public health emphasis) and the relevance of human rights concepts in analysis and response to health problems (human rights emphasis) has now (more than ever before) jointly enhanced our potential to reveal previously unrecognised difficulties and limitations with simple forms of analysis.

From the public health perspective, we do know about the so-called "societal factors" that constitute the major determinants of health status. Yet, despite much analysis (for example how social disadvantage and poverty drives poor health outcomes), we are only beginning to understand how social structure and human agency interact in complex ways to produce health outcomes. The health and human rights linkage, however, advocates for more insight and experience than bland data; it provides a better guide for identifying, analysing and responding directly to critical societal conditions than traditional public health approaches that have been preoccupied with individual-level factors and behaviours associated with health risks and illness. Our history and experience in the HIV and AIDS field has repeatedly taught us lessons of "neglecting the social" in our analysis.

In contrast, adopting a social compact, which takes a *critical public health and human rights analysis* — which is to say a societally based analysis — necessitates a readjustment in our frame of reference towards failures of rights realisation and the violation of human rights, and its associated burdens on dignity which constitute the societal roots of health problems. It also alerts us to how state and non-state actors affect rights, and in what way the state's responsibility on health and welfare is invoked in areas of life that used to be considered part of a private sphere outside the ambit of rights — such as rape and domestic violence.

The three sets of reforms that have recently been tabled, two in bill form (NHI and Medical Schemes Amendment Bill) and a third the outcome of the Health Market Inquiry into the private health system, are viewed as central axes for such a conversation. It requires bringing a critical assessment of the evidence to inform debates on healthcare while including contextual and experience-based perspectives to understanding quality and access to healthcare. The latter point is important because access to healthcare is not the same for all people living in South Africa, with quality of access grounded in the daily struggles of vulnerable people (the elderly, people with disabilities, children and adolescents, sexual minorities, people working in the informal sector, people with chronic health conditions).

Equally importantly, the use of human rights language to frame this conversation means affirming the constitutional obligations of government, private and public actors to ensure the right to healthcare services is realised. At constitutional and programmatic level, the health and human rights analysis needs to inform dialogues on how we take forward a notional NHI into actuality. It requires more debate on the nature and form of a single and integrated health system and where exactly will the trade-offs occur in terms of coverage of services in light of finite resources and what this means for realising the health and human rights of all.

The NHI debate cannot be dominated by a "financing of health" language: the absence of human rights principles and safeguards can easily translate to sectors of our population being left behind in healthcare. Universal health coverage also requires a distinctive pro-poor emphasis in government policy – a commitment to poor and disadvantaged or excluded groups and communities – noting that most health systems are weak or dysfunctional in less developed regions, rural areas and when servicing vulnerable populations.

The recent findings of the Black Sash and UWC study are illustrative of this – people in rural areas and the elderly are paying more on travel and fees to access social grants at ATMs and post offices as a result of the new system and with the phase-out of CPS in 2018. There is also ample evidence showing that people of different sexual orientations and gender expressions are routinely stigmatised and prejudiced against when accessing health care.

A critical and reflexive assessment of South Africa's health reform landscape using an evidence-based perspective and human rights approach can meaningfully inform how we move forward to achieve a single and equitable health system. Therefore, it comes as no surprise that the Finance and Fiscal Commission (FFC) has told Parliament that the 2026 deadline to roll-out the NHI is completely unrealistic. The commission indicates that there are significant hurdles to be overcome at a structural, political and operational level if we are to realise healthcare for all. Given South Africa's history of disjunctures that we often see between policy and implementation, it will do well to heed the warning of the FFC and like-minded agencies.

Transcending a solidarity of exclusion to achieve a solidarity of inclusion requires more time for dialogue and engagement with multiple and diverse constituencies. Section 27 of the Constitution reflects a pact entered into by all state and non-state actors, with the state being the principal agent in respecting, protecting and fulfilling the progressive realisation of rights of citizens. So, rather than kneeling to political pressures and pushing forward in haste to have these two bills pass legislation, it would be wise to heed these warnings and instead opt for a more well-thought-out approach to how we envisage universal health coverage. **DM**