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The National Health Insurance policy: What's in it for women's health in South Africa?

Rebecca Amollo

abstract

Several countries in Latin America and Asia have covered their populations by a national health insurance (NHI). In 2007, the South African government renewed its commitment to implement an NHI as part of its health reform plans. In August 2011, the government released a Policy Paper (Green Paper) on the NHI. Against this backdrop, this *Article* argues that the adoption of an NHI could serve as one of the building blocks to achieving the highest attainable standard of health for women. The *Article* also clarifies what national health insurance is. It further examines the proposed NHI through the normative features of the right to the highest attainable standard of health. In doing this, the *Article* discusses the Policy Paper with the purpose of analysing its utility for improving women's health in South Africa. It concludes, *inter alia*, that the establishment of an NHI could represent a step towards realising women's rights to health, depending on the way that it structures and organises care in South Africa's health system.

keywords

National Health Insurance (NHI), women, health, South Africa

The current state of South Africa's health system

South Africa is plagued by four clear health problems that have been defined as 'the quadruple burden of disease'. These are HIV and AIDS and tuberculosis (TB); maternal, infant and child mortality; non-communicable diseases and injury and violence (Norman *et al*, 2006). South Africa with 0.7% of the world's population, bears 17% of HIV infected people. The rate of TB infection is one of the highest in the world. HIV infection is 23 times the global average, and the TB and HIV/AIDS co-infection rate is one of the highest at 73%. As a result of the burden

of disease, South Africa's life expectancy has declined.¹ HIV/AIDS has continued to contribute to high maternal and child mortality rates. The Department of Health 'National Health Insurance in South Africa – Policy Paper' (Green Paper) (2011b), warns that gains made over 50 years are in danger of being lost. The National Health Insurance (NHI) Policy Paper also notes the high rate of non-communicable diseases (28% of the burden of disease) including in this the high rate of violence, particularly violence against women and children, as contributors to the injury burden which the health care system is carrying.

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While the Policy Paper (DoH, 2011b) does not provide gender disaggregated figures on the burden of disease, this *Article* focuses on HIV and AIDS which has been documented as one of the most critical areas as one in which women bear the greatest brunt of the burden of preventable sickness, communicable disease and violence, and remains a specifically gendered area of concern for women who carry a disproportionate share of the burden of care. While the country's health system can barely cope with the challenge of the 'quadruple burden', the question is how will the reforms outlined in the policy document improve delivery of women's health to vulnerable groups of women who presently face different degrees of exclusion, and improve the health indicators for the population reported by the Department of Health. The health system consists of a large public sector and a smaller but fast-growing private sector. According to the Department of Health it varies from the most basic primary health care service, offered free by the state, to highly specialised health services available in the private sector for those who can afford it (DoH, 2008). The state spends 8.5% of the Gross Domestic Product (GDP) on health – higher than the minimum standard set by the World Health Organisation (WHO) which is 5% (Schieber *et al*, 2006). According to the Council for Medical Schemes (CMS), the public health sector is under pressure to deliver services to about 84% of the population (CMS, 2009).

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Despite this high proportion of the population that is dependent on public health care services, most resources are concentrated in the private health sector, which sees to the health needs of the remaining 16% of the population (DoH, 2008). The public sector is largely under-resourced and stretched beyond capacity, while the mushrooming private sector, run largely along commercial lines catering to middle- and high-income earners who tend to be members of medical schemes (DoH, 2008). The private sector also attracts most of the country's health professionals and is primarily funded through contributions to mu-

tual insurers or medical schemes (Shisana *et al*, 2006). Although only 16% of the total population of 50 million benefits from private health insurance coverage, 60% of total health funds were spent in the private sector in 2006 (McIntyre and Thiede, 2007). Most women's lower income precludes them from joining medical schemes (unless part of employer benefits) and the majority of the country's women depend on the health care services that are delivered by public health facilities. In this regard, McIntyre and Thiede (2007) have correctly argued that the socio-economic status of an individual in South Africa is the primary determinant of the system through which the individual will receive access to health care.

South Africa faces a further problem that has dented the capacity and resources of the health system – the migration of health care providers. As a result of the stream of nurses and doctors to other countries, frontline health workers such as nurses are required to implement organisational management changes. A study that attempted to quantify the shortage of staff in health facilities found that overall, hospitals and clinics had a vacancy rate of 22.6% and 26.5% respectively, with clinics in Mpumalanga having the highest vacancy rates (Penn-Kekana *et al*, 2005). Most (83%) hospitals, but only 11.1% of clinics had advanced midwives and 42% of facilities reported that they had lost an advanced midwife during the last year. Poor implementation and a lack of understanding of human resource needs and the socio-political context resulted in deteriorating quality of care and decreased staff motivation. The HIV/AIDS epidemic was found to have a role, but not to be driving problems with nursing morale in maternity units (Penn-Kekana *et al*, 2005). The consequences of this are wider as demotivated staff are more likely to join the exodus of professionals. Since 1996, 37% of South African doctors and 7% of nurses have migrated to Australia, Canada, Finland, France, Germany, Portugal, United Kingdom, and United States compared with 34% of educators, 29% of engineers, and 24% of accountants.² The loss to the country's public health system of health care professionals has consequences for the quality of health care it is able to provide. Not surprisingly, according to the Department of Health:

“one of the biggest threats to NHI is the unequal distribution of health professionals between the private and public sector, and between urban and rural areas” (DoH, 2011a:14).

Since 1994 the government has endeavoured to:

“ensure that everyone in this country has health care. Our government health budget has kept increasing and our network of public hospitals and clinics has grown.

But still there are communities in rural areas that cannot easily obtain care. Many residents in our major cities rely on overcrowded public health facilities with too few health professionals and poor equipment. In short, many people cannot yet get the care that they need” (DoH, 2011a:5).

The unequal distribution of health care, deteriorating infrastructure, poor management and the lack of human and financial resources to deal with the ‘quadruple’ burden of disease was thus part of the rationale for the South African government to develop a proposal to introduce a NHI scheme. A number of challenges have to be faced in ensuring that health becomes a public good, particularly for vulnerable sectors of the population as poor quality of services has been shown to be a major barrier to access to the health care that is needed by the sick.

In the *Article*, I argue that the NHI could become a means by which women’s rights to health are potentially delivered more fully than is possible by the present fragmented and skewed or unequal system. The first section of the *Article* provides some background to the development of the proposal. It then goes on to describe the history of the debate around the NHI and to differentiate an NHI from the current medical aid system. Finally, I discuss the NHI scheme’s potential implications for the progressive realisation of women’s rights to the highest attainable standard of health in South Africa, and argue that this is contingent on the provision of sufficient human and other resources to support the extension of primary health care provision by the NHI to meet women’s gender-specific health needs.

Background to the NHI

The aspiration to implement an NHI was reaffirmed at the African National Congress (ANC) National Policy Conference of 2007.³ In 2009, the South African ANC government committed to introduce an NHI in its manifesto and placed the NHI at the top of 10 health care priorities. However, it is not unusual for health policies to be proposed and to be used as political ‘gimmicks’ to sustain popularity in developing countries, as has been documented in Brazil, Colombia and Venezuela (De Negri Filho, 2008). The right to health can also be used as a driving force for political action. I propose that the political debate around the NHI be developed into policy debate in which women’s organisations and health activists ensure that the delivery of women’s health is a priority, and then public policy and law, so that systems, services and actions can be developed and coordinated to realise the right to health for South Africa’s population, as a whole. Discussing how to reform and improve our health system’s delivery of health care services in terms of law and policy, recognises that such processes are not gender-neutral, and that while it can facilitate a leap from political rhetoric to action, the action needs to guard against the possibility that women’s health needs and delivery needs are merged in the representation of a homogenous gender-neutral population which presents all needs as the same. As a discussion document, the Policy Paper calls for comments, and it is expected that a gender-responsive bill will result from the process, as the gender analysis of health requires that we take note of how men and women are differently affected in epidemiological research, and in relation to the social and other causes impacting on the population’s health and, therefore, that the health delivery system needs to note this for both planning, outcomes and monitoring.

a number of challenges have to be faced in ensuring that health becomes a public good

Since 2009, several steps were taken towards developing the NHI proposal. On 12 August 2011, the Department of Health issued the Policy Paper.⁴ Against this backdrop, this *Article* argues that the

implementation of a NHI could serve as one of the basic but critical elements for the achievement of health for the majority of women, now dependent on the public health services. This position does not ignore the NHI's potential to deliver health benefits for the entire population, however, it emphasises that improved women's health has been shown to hold household-level and community-level health benefits for the poor. The NHI Policy Paper (DoH, 2011b) examines the proposed system in terms of the ways in which it could advance the health-related ethics of availability, accessibility, acceptability and quality.⁵ Before describing the implications for women's rights to health that the NHI could hold, I offer an outline of the history of the NHI in South Africa.

The history, debate and contestations of the NHI

The NHI debate has been on the health agenda since before the democratic transition in 1994. It has for long been proposed as a policy option to guide the transformation agenda towards universal coverage (Botha and Hendricks, 2008). Both then and now, the argument has rotated around funding models, organisation and the role of the private sector. The government's initial proposal for an NHI was severely criticised by the National Treasury and health professionals for being too costly and too rigid (Shisana, 2008).

The contestation led to the establishment of a Committee of Inquiry into an NHI in 1995. Its mandate was to investigate the appropriateness and economic feasibility of an NHI within the South African context and to undertake a detailed planning for its implementation. The Committee of Inquiry was also tasked to consider a range of structural and institutional frameworks for the NHI. Some of the questions that it raised were, should the NHI be a single state or parastatal NHI, a single privately administered NHI, or an NHI with the current medical aids acting as the financial intermediaries with pooling of contribution revenue for risk adjustment? The Committee recommended the medical schemes as a vehicle towards a national health system (Shisana, 2008).

It was subsequently felt that the 1995 Committee of Inquiry fell short of promoting a system of 'access to health for all'. This led to the establishment of the 1997 Committee which revised the 1995 Committee's recommendations and argued for a phased approach towards ensuring 'access to health for all' by means of a Social Health Insurance (SHI) with the NHI as a second step (Shisana, 2008).

In 2000, the Cabinet appointed a further Committee of Inquiry, this time into a Comprehensive System of Social Security for South Africa, which investigated how to secure and enhance social protection (the social protection concept is broader than the narrow focus on social security) for all South Africans. Health services and health care funding formed part of this inquiry. With regard to health, as one of its recommendations the Committee advocated an incremental approach toward an NHI system. This approach envisages the integration of the public sector health delivery and the medical schemes, based on a contribution system that would rely on multiple sources of funds, as opposed to a single-payer model to achieve full coverage (Amollo, 2009).

The Policy Paper (DoH, 2011b) details several aspects of the proposed NHI scheme, including: its guiding principles; socio-economic benefits; the health care benefits which would be provided under the scheme and the role of medical schemes. In the next section I outline more fully the NHI scheme which the government is proposing to introduce.

National health insurance v medical aid system

It is important to clarify the differences between a medical aid system and the proposed NHI. Currently South Africa has several medical aid systems which are a form of health insurance. Health insurance may be provided through a government-sponsored social insurance programme, or through private insurance companies. It may also be purchased on a group basis (eg by an employer as a benefit to cover employees' health) or purchased by individual consumers. In each case, the covered groups or individuals pay premiums or taxes to help protect themselves from high

or unexpected health care expenses for themselves and their dependents. An NHI, on the other hand, is a type of national health system introduced by government. An NHI provides for both contributors and non-contributors in a universal system. Further, it is also important to distinguish an NHI from an SHI, which is another form of national health system. Unlike the NHI, an SHI offer benefits to the contributors only. This means that it is not universal and as a result only those who contribute are beneficiaries. Initially, it was argued that an SHI could be the starting point to achieve an NHI for South Africa (Amollo, 2009). Typically, an NHI system ensures universal coverage and it, therefore, offers a mechanism for providing equitable access to quality health services, thereby, promoting the principles of a unitary system based on redistribution and sharing of resources. As the Minister of Health stated in the debate on the health budget in the National Assembly on 30 June 2009:

“NHI is a system of universal health care coverage where every citizen is covered... rich or poor, employed or unemployed, young or old, sick or very healthy, black or white” (Motsoaledi, 2009).

It is beyond the scope of this *Article* to delve into the financing of an NHI, a subject well examined elsewhere (see McIntyre and Ataguba, 2012; McIntyre, 2010). However, it needs to be noted that there are two means of financing an NHI: a general taxation system and compulsory health insurance. Some countries (like the UK or Sweden) have chosen the tax route, while others (like France, Germany, and Latin American countries) have chosen the insurance route. The NHI Policy Paper (DoH, 2011b) proposes that a combination of the two be used – a direct tax allocation will be supplemented by mandatory contributions linked to deductions from the payroll of the employed, called the Kutzin approach (Kutzin, 2001). There will be a tax that will be administered by the South African Revenue Services (SARS), and a mandatory contribution from payroll deductions made to the National Health Insurance Fund. The Treasury will allocate general tax revenue from the budget for health care services and administer the payroll-linked mandatory contribution to NHI in consultation with the Minister of Health and

the body responsible for administering the NHI. The new system will therefore in effect redistribute resources to achieve a cross-subsidisation of the poor by the rich. Payroll contributions will be based on income.

Under the NHI, private purchasing of health care will continue to exist on a voluntary basis for doctors, dentists, specialists and other health care providers. They can choose to serve patients who choose to pay them privately. There will be doctors and specialists who will see a mixture of patients, some paid for by NHI and some who prefer to pay from their pockets or through medical aid, hence, medical schemes will continue to function alongside the NHI. However, because the government will no longer provide tax subsidies for medical scheme contributions, it is expected that fewer people will continue with medical schemes contributions, hence, medical schemes are expected to provide new options, focusing less on ‘full cover’ and more on ‘topping up’ the care offered by NHI (DoH, 2011b).

An NHI provides for both contributors and non-contributors in a universal system.

Solidarity is a core principle of the NHI. This principle means that health care should be financed by individuals on the basis of their ability to pay, but should be available to all who need it on roughly equal terms (Amollo, 2009). In the South African context, where there is ‘feminised poverty’, the author is optimistic that women have the potential to benefit from the proper implementation of an NHI. Moreover, in light of the gap between private and public health care, the NHI could enhance women’s access to health services.

Whether the government has the resources to implement the NHI to re-organise the platform on which health care delivery is structured, managed and financed is addressed in the Policy Paper. The NHI will require an increase in public spending to roll out the envisaged upgrading and extension of services. It is estimated that the cost will amount to 6.2% of GDP, compared with the combined current public spending on public health care and spending via medical aid contributions which currently amounts to 8.5% (DoH, 2011b). A more efficient use of the existing resources is required, with a

broad revenue base to achieve the lowest contribution rate needed to generate sufficient funds. Given the current unequal distribution of health resources and access to health by the sick, the proposed system represents a progressive fiscal policy which reaches across the wealth/poverty gap to redistribute resources between those who have access to health care and the poorest, particularly women.

the question of how women's health is treated in policy, relates not only to women as half of the population but to gender-specific needs within the context of women's share of the burden of disease

The next section of this *Article* explores the potential of an NHI to improve women's health in South Africa against the normative framework of the right to the highest attainable standard of health.

What's in it for women?

Health movements and approaches are in agreement that the right to health should be the cornerstone of any consideration of national health (Hunt and Backman, 2008). The right to the highest attainable standard of health is provided for in several human rights instruments, notably: the International Covenant on Economic, Social and Cultural Rights (ICESCR)⁶; the Convention on the Elimination of All Forms of Discrimination against Women (CEDAW)⁷ and the Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa (African Women's Protocol).⁸ In 1999, the UN Committee on the Elimination of Discrimination Against Women gave concrete expression to the content of the Article on the elimination of discrimination against women and health.⁹ In 2000, the UN Committee on Economic and Social Cultural Rights elucidated on the content of the right to the highest attainable standard of health¹⁰

Domestically, the South African Constitution provides for the right to access to health services, including reproductive health care in section 27(1)(a). This was also considered in the celebrated case of *Minister of Health and Other v Treatment Action Campaign* (2002 (5) SA 721 (CC) in

which the Treatment Action Campaign, an activist organisation, won its case that the state should provide antiretroviral medication free of charge to HIV-positive pregnant women and their new-born babies at public sector antenatal health facilities to prevent mother-to-child transmission of the virus. Furthermore, the Medical Schemes Act, No 131 of 1998, seeks to promote access to affordable private health care for those who are unable to pay for their health care. Also, the National Health, Act No 61 of 2003, mandates the Minister to ensure that there is adequate provision of health services within the limits of available resources. What is discernible from both the international and national perspectives is that the conditions prevailing in a state should include the essential elements of availability, accessibility, acceptability and quality.¹¹

Currently, the NHI Policy Paper is still open for public comment, prior to the drafting of law for consideration by Parliament. A key question is whether the NHI, as presented in policy, can be seen to have the potential to improve women's health in South Africa and what possible gaps and shortcomings might exist.

The right to health is a means to achieving real and full freedom for women and as a right is one that women, if they are able to exercise it fully, can have results that will in the long-term be extended to benefit households/families and communities through for example, freeing resources spent on health and reducing time burdens of care. When it is viewed through the lens of women's gender-specific health concerns, the critical nature of the right to access to health care services is very apparent (Mushariwa, 2011). The question of how women's health is treated in policy, relates not only to women as half of the population but to gender-specific needs within the context of women's share of the burden of disease, and also to how women's health and empowerment has broader results. Women bear a bigger burden for protecting and promoting the health of others as a result of their gender-specific responsibilities and roles as mothers and providers of care for their families. Mushariwa (2011) notes, it is women who are generally responsible for looking after the psychological and physical wellbeing of children, and members of the extended family. As stated, earlier, in the

South African context, one of the most critical health issues with specific health impacts for women is HIV and AIDS. Women's health and their health care needs are defined by both biological factors and socially constructed roles as the primary caregivers for their families. Women have been shown to be more vulnerable as a result of their physiogomy to HIV infection and are also more vulnerable as a result of social and economic inequality and the consequent unequal access to resources. Women's sexual and reproductive rights are an important gender-specific aspect of women's right to health and women's rights to contraceptive choices, free maternity care, legal termination of pregnancy, and treatment for sexually transmitted diseases, are an important element of South Africa's health policy that are in place. It needs also to be noted that women also constitute the majority among the poor and are also ranked as among the poorest in poverty statistics, and in most rural communities their responsibilities include the collection of water and fuel for survival. As a result they are also more likely to be more exposed to and affected by diseases that result from poverty and poor access to resources and services needed for survival - such as cholera and TB. Women are also likely to experience greater risks to their health from their greater exposure to poorly paid, unprotected and precarious work, such as domestic work, sex work and informal work such as market or street traders with little income (De Bruyn, 1992; HSRC, 2008; Katz and Low-Beer, 2008). The WHO (Bushan, 2008) note the importance of the gender analysis of health policy to ensure that its impacts are responsive to women and men's different roles, responsibilities and gender-specific needs in health care prevention and delivery. I next question how the NHI could provide an improved system that addresses women's specific health challenges more effectively.

One challenge is that women continue to face discrimination in health services, linked to inequities in access to health services mainly caused by lack of facilities, overstretched facilities and poverty (Greene and Merrick, 2005). Access to antiretroviral therapy has been central to the demands for access to health services and medication for all. Although there is no known cure for HIV and AIDS, antiretroviral drugs provide treatment that has prolonged the lives of people

living with HIV, especially for HIV-positive mothers, and babies and children who are infected through mother-to-child transmission. Through the roll-out of this medication, HIV has become a medically manageable condition. However, the universal access to treatment still has no meaning for many women who still do not have access to comprehensive HIV treatment and care (Eyakuze *et al*, 2008), particularly women living in rural districts (Amnesty International, 2008). A further problem is that women who seek assistance from health care providers are often shunned. The reinforcement of gendered stigma by health care providers for instance is reported in a study in the Eastern Cape where health care providers referred to women living with HIV and AIDS as "suicide bombers" (Stevens, 2008:353). Furthermore, there are allegations that women living with HIV have been forced to undergo abortions and sterilisation when they visit health facilities (Eyakuze *et al*, 2008) in breach of ethics and women's right to exercise choice and make informed decisions. In the contemporary South African public health system, the ethical principles of respecting patients' dignity and confidentiality are also reportedly often violated (Ngwena and Cook, 2008). Women's rights to health must be respected by the public health system to ensure that the clinical management of women is ethical. Health care centres should provide a congenial environment in which women are fully informed and supported in their decision-making regarding health care treatment and provided with an avenue of complaints that is supported by the health care system management to prevent their recurrence.

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South Africa's maternal mortality rate is much higher than that of countries of similar socio-economic development. A report by Human Rights Watch which is discussed in greater detail elsewhere in this journal issue (see Stevens pg 42) investigated reasons for South Africa's maternal mortality ratio increase from 150 deaths per 100 000 live births in 1998 to 625 in 2007 (Human Rights Watch, 2011). As 97% of women give birth in public health facilities and most receive

prenatal care, the report which details abuses of women attending health care facilities, has flagged one area where the system needs to improve, both in relation to the poor quality and unevenness of access to health care for vulnerable women, but also in the standard of health care that women should be able to expect.

Generally, women face problems in accessing appropriate services which meet their specific health needs. This *Article* commends and supports the plan to implement an NHI as a possible step towards improving the state of the health system, and women's health generally, provided that sufficient human and other resources are provided within the context of primary care to translate the vision of the NHI, and implement the improvements that are needed.

The right to health entails that health services should be available, accessible, acceptable and of the highest possible quality.

Before one can grapple with the possible potential of the NHI, it is important to examine women's rights to health and also establish how these can be enforced. The right to health entails that health services should be available, accessible, acceptable and of the highest possible quality. The UN Committee on Economic and Social Cultural Rights (CESCR) as the body of independent experts that monitors implementation of the ICESCR has explained what these elements mean for state parties, or states that have ratified or acceded to the treaty and are therefore bound by the terms of the treaty. A 'state party' to a treaty is a country that has ratified¹² or acceded¹³ to that particular treaty (or Covenant), and is therefore legally bound by the provisions in the instrument. All states parties are obliged to submit regular reports to the CESCR on how the rights are being implemented. Apart from state reporting, another procedure exists which allows individuals to bring complaints to the CESCR. Here, any individual who claims that her or his rights have under the Covenant have been violated by a state party to that treaty may bring a communication before the relevant committee, provided that the state has recognised the competence of the responsible Committee to receive such complaints. It is important to

note that South Africa is not yet a party to the ICESCR. However, the South African Constitution provides under Section 39(1)(b) that when interpreting the Bill of Rights, a court, tribunal or forum must consider international law.¹⁴ Fortunately, South Africa is a party to the CEDAW. This means that the Government is obliged to report to the Committee on the Elimination of Discrimination against Women which is the body of independent experts that monitors implementation of the Convention. Individual complaints can also be brought under this Convention.

Within the context of health, the CESCR has elaborated that availability entails functioning public health and health care facilities, goods and services, as well as programmes, all of which have to be available in sufficient quantity. The precise nature of the facilities, goods and services will vary depending on numerous factors, including the state's developmental level. The nature of health services is also shaped by the underlying determinants of health, such as safe and potable drinking water and adequate sanitation facilities, hospitals, clinics and other health-related buildings, trained medical and professional personnel receiving domestically competitive salaries, and essential drugs, as defined by the WHO Action Programme on Essential Drugs.

According to the CESCR (UN, 2000), accessibility entails that health facilities, goods and services have to be accessible to everyone without discrimination, within the jurisdiction of the state party. Accessibility has four overlapping dimensions:

- Non-discrimination: health facilities, goods and services must be accessible to all, especially the most vulnerable or marginalised sections of the population, in law and in fact, without discrimination on any of the prohibited grounds.
- Physical accessibility: health facilities, goods and services must be within safe physical reach for all sections of the population, especially vulnerable or marginalised groups, such as ethnic minorities and indigenous populations, women, children, adolescents, older persons, persons with disabilities and persons with HIV/AIDS. Accessibility also implies that medical services and underlying determinants of health, such

as safe and potable water and adequate sanitation facilities, are within safe physical reach, including in rural areas. It further includes adequate access to buildings for persons with disabilities.

- Economic accessibility (affordability): health facilities, goods and services must be affordable for all. Payment for health care services, as well as services related to the underlying determinants of health, has to be based on the principle of equity, ensuring that these services, whether privately or publicly provided, are affordable for all, including socially disadvantaged groups. Equity demands that poorer households should not be disproportionately burdened with health expenses as compared to richer households.
- Information accessibility: accessibility includes the right to seek, receive and impart information and ideas concerning health issues. However, accessibility of information should not impair the right to have personal health data treated with confidentiality.

On acceptability, the CESC (*ibid*) has explained that all health facilities, goods and services must be respectful of medical ethics and cultural appropriateness, ie respectful of the culture of individuals, minorities, peoples and communities, sensitive to gender and life-cycle requirements, as well as being designed to respect confidentiality and improve the health status of those concerned. Regarding quality, the CESC (*ibid*) elucidates that as well as being culturally acceptable, health facilities, goods and services must also be scientifically and medically appropriate and of good quality. This requires, *inter alia*, skilled medical personnel, scientifically approved and unexpired drugs and hospital equipment, safe and potable water, and adequate sanitation.

Women's health: The case for a national health insurance system in South Africa

The NHI Policy Paper sets out the principles that will guide its implementation. These are: right to access, social solidarity, appropriateness, equity, affordability, and efficiency (DoH, 2011b). Currently public

sector health services are free to the unemployed and those without income (and are charged according to income for the employed), but limited in their availability and in the quality of services provided. On right to access, the policy states that health services must be "free at the point of use" (NHI, 2011b:16) and that people will benefit according to their health profile. If well implemented, the provision of equity is critical to make health services more available and accessible to the population, not least of all women. This is especially so in light of the fact that affordability is one of the factors hindering women's access to quality health services and those provided by private health services. Providing free health service to the population is intended to have the effect of ensuring universal coverage in the delivery of health services. The provision of free health care services to all on an equal basis could represent a step towards eradicating the discrimination that women face in accessing the health services needed to reduce the burden of disease among women and for effective prevention and cure.

the goal of universal access for all at the point of access has potential to achieve a far wider coverage of health delivery than in the past

One positive feature of the system, relating to how equity will be translated into access at point of care is for the same NHI health care card to be issued to everyone who is eligible, that is anyone who is a legal resident: the Policy Paper notes that this system is intended to avoid the stigmatisation of groups who are for whatever reason socially disadvantaged. One of the consequences of a card system will be that health care services will also therefore be portable. The NHI policy also states that refugees and those seeking asylum will be entitled to health coverage under the existing laws and human rights conventions. The goal of universal access for all at the point of access has potential to achieve a far wider coverage of health delivery than in the past, particularly given the migratory nature of much of the work performed by the urban and rural poor.

The inclusion of 'appropriateness' as a guiding principle of the NHI is of paramount importance, particularly as a critical element

of health care services for women.¹⁵ Appropriateness in the NHI Policy Paper relates to the adoption of new and innovative health service delivery models that take into account the local context and the need to be responsive and acceptable to local needs. For example, given that women are already marginalised within the context of HIV and AIDS and have been described as 'vectors' of disease (Faithfull, 1997), it is imperative that the clinical management of health facilities is conducted in a manner respectful of HIV-positive women, that does not seek to marginalise or increase their vulnerability further. HIV and AIDS related services for women should take into account scientific and medical appropriateness, for example, that a contraindicated medication for an HIV infected pregnant woman cannot be used (Amollo, 2011).

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The principle of solidarity relates to the creation of financial risk protection for the entire population that ensures sufficient cross-subsidisation between the rich and the poor, and the healthy and sick. Such a system allows for the spreading of health costs over a person's lifecycle: paying contributions when one is young and healthy and drawing on them in the event of illness later in life. The benefits of universal free health care could translate into better health for women and that of their families and savings that could be spent in other areas of their lives, such as food and education, and meeting needs which have the possibility of leading to further wellbeing.

The objectives of the NHI policy provide for a system within which women's health needs, while not distinguished from the general population could be catered for.

The objectives include:

“to provide improved access to quality health services for all South Africans irrespective of whether they are employed or not; to pool risks and funds so that equity and social solidarity will be achieved through the creation of a single fund; to procure services on behalf of the entire population and efficiently mobilize and control key financial resources and

to strengthen the under-resourced and strained public sector so as to improve the health system's performance” (DoH, 2011b:18).

The NHI policy presents the improved delivery as contingent on the re-engineering of the Primary Health Care system (PHC), rooted in the public health primary health care philosophy.¹⁶ The policy elaborates that the re-engineered PHC services will focus its services mainly on community outreach. Furthermore, the policy states that on-going efforts to reengineer the PHC approach will ensure that the composition of a defined comprehensive primary care package of services extends beyond those traditionally provided in health facilities such as clinics, community health centres and district hospitals. Within the PHC system, services will be delivered according to three streams: district-based clinical specialist support teams supporting delivery of priority health care programmes in a district; school-based PHC services and municipal ward-based PHC agents. This provision has the potential to reduce the glaring gap between public and private sector health provision. Moreover, it holds the prospect of ensuring greater equity in the provision of health services. The ripple effect would be to improve the accessibility to health services for vulnerable populations. As stated earlier in this *Article*, many rural women face challenges in accessing health services. With the planned provision of PHC at district levels beyond hospitals, there is the possibility that health care will be brought within closer reach of many more women.

In order to address high levels of maternal and child mortality and to improve health outcomes, an integrated team of specialists will be based in the districts. The specialities will include: a principal obstetrician and gynaecologist; a principal paediatrician; a principal family physician; a principal anaesthetist; a principal midwife and a principal primary health care professional nurse. This provision of emergency and technical support is welcomed as it clearly is critically needed to address the high rate of maternal mortality. The allocation of obstetricians, gynaecologists, midwives and primary health care professional nurses in districts, therefore, has the potential to ensure that

women are attended to by appropriately qualified health care givers.

The NHI Policy Paper states that the Government has failed to create an equitable system to meet the needs of the population because of the large gaps in the racially-based apartheid health system inherited, noting poor management, failing infrastructure, stock outs, inadequate standard of care and access for the people that most need it. One of the main challenges is therefore to completely change the basis on which health resources are allocated to a more rational and efficient system for a stronger platform of delivery. The approach emphasises prevention and referral over hospitalisation and cure which have been concentrated in the private health delivery available to an increasingly small group because of the high cost to contributors.

Given the shortage of resources, PHC services will be delivered through accredited and contracted private providers practicing within a District as well as the existing, upgraded public health care facilities. As noted, private health care is expensive and more often than not it involves considerable out of pocket payment. Under the NHI, private providers can participate in providing PHC services to the population. Thus, the salient feature of contracting private providers in the delivery of primary health care services will entail the specification of the range of services that will be provided. These may include services by the general practitioners to patients who must get the full range of primary care services required in one facility or a comparable arrangement which does not inconvenience or require travel costs on the part of the patient. This provision is an important measure to address the concentration of resources in the private sector and to integrate the country's health delivery systems to serve the population's needs. It also has the potential to reduce the gap between public and private health care provision and raise the level of care available to the sick.

The long awaited Office of Health Standards Compliance (OHSC), to be introduced through an Act of Parliament, will have the task of addressing *inter alia* complaints, standards and accreditation. The OHSC will have three units, namely: inspection, norms and standards and the office of the ombudsperson and will undertake the in-

spection all health facilities. The process of inspection will be undertaken with the implementation of quality improvement plans and infrastructure upgrading to ensure facilities are ready for accreditation and contracting with the NHI. Interim assessments, focusing on high-risk elements in public health facilities, will be conducted within regular intervals to ensure that the appropriate set standards are maintained. The policy states that recommendations will be made on the introduction of continuous quality improvement in public health care facilities, with the associated training of nurses. As stressed by Human Rights Watch (2011), the establishing of clear accountability and functioning channels for complaints are basic to ensuring that the rights to health are respected and that health care standards are maintained. If well-implemented, the OHSC will be a watchdog over health care delivery and the NHI. This office therefore, will offer institutional support to the department of health which has been lacking.

Still on accreditation, all health establishments, including those in the public and private sectors, that wish to be considered for rendering health services to the population will have to meet set standards of quality. These standards deal with key quality principles that will improve safety and facilitate access to health care services. The process of accreditation should enhance women's access to quality health care providers, and it is hoped that the OHSC uses its authority to eliminate practices that have brought the health system into disrepute.

Budgets clearly need to ring fence women's health needs for maximum health outcomes to be achieved.

The analysis offered is not exhaustive of all the potential benefits of an NHI, nor does it seek to ignore the many challenges in the implementation of an NHI. Nevertheless, for the implementation of the policy to be described as cognisant of the gendered implications and consequences of health delivery, and the gender-differentiated needs of women and men in the population, the state should integrate a clear gender perspective into the policy and law for provision of health services, the training of

health personnel, the structuring of facilities, planning and programmes. Budgets clearly need to ring fence women's health needs for maximum health outcomes to be achieved. Monitoring and evaluation should recognise the important role of both biological and socio-cultural factors that influence the health of women. Research should prioritise women's biological needs in relation to sexual and reproductive health services, such as contraception and antenatal services (Amollo, 2011).

Furthermore, the success of the NHI in improving women's health will depend on the structures it creates and the way it organises care. The White Paper and draft bill on the NHI is expected to be published this year. Some issues that law and policy will need to address relate to districts, and the need to flesh out how under-served areas in poor and rural districts will be more equitably covered under the district system which is at the heart of delivery of a re-engineered PHC. Will this occur through extension or creation of new districts and what will the population coverage of districts be? This is not spelt out and clearly needs to be included in plans to meet the objectives of equity and accessibility in order that vulnerable groups of women will be reached more efficiently under the NHI, eg: women in informal settlements, in deep rural communities, undocumented workers (migrant workers) as well children and the elderly, and younger women and men in HIV/AIDS prevention and education (to ensure that the responsibility for prevention and caring is one shared by both sexes to mitigate against the further marginalisation of women). Another concern is how the health care prevention services will be extended to include testing for gender-specific diseases, for example cervical and breast cancer for women (see Mthembu, pg 33). The NHI policy should give some attention to how the gendered burden of disease is understood and approached in policy. A pertinent example is the large number of women and children who are victims of gender violence. The provision of health services by health providers to meet the needs of this group of vulnerable women who are affected by injury in the population, has been raised in policy but not implemented and needs to be addressed in the nurses training that the NHI

Policy Paper has identified as necessary (see Ashman *et al* in this issue, pg 49).

The implementation of the NHI will take time as it will be done in a phased and systematic manner at both the national and sub-national levels. Implementation will occur in three phases over 14 years. Other country's experiences with implementing such systems reflect that achieving universal coverage may take a considerable amount of time. For example, implementing such health reform took Germany close to 100 years; and South Korea 12 years to cover the whole population, including the poor, the unemployed and the self-employed (Kwon, 2009).

Conclusion

This *Article* has examined the possible benefits of an NHI for women's health in South Africa. The government's commitment to implement an NHI is commendable. The NHI extends beyond mere rhetoric in terms of the way it will advance the principles of solidarity, appropriateness, equity, availability, accessibility, acceptability and quality. It will also go a long way towards addressing the uneven and non-existent services available to many groups of rural and vulnerable women, such as HIV-positive women, refugees and undocumented workers. If the NHI is well implemented, it could represent a milestone in the improvement of women's well-being. However, the success of the NHI in accomplishing its goals will depend upon an array of factors including: the structures it creates; the way it re-organises care and human and other resources and the extent to which the government manages to obtain buy-in from some private sector providers and actively involves women in its design and planning for its introduction. Without a specific focus on the addressing of women's health needs, the NHI policy may be relegated to a mere paper tiger.

Notes

1. A comparison of the mortality rates for example between Chile, a southern-based country, reflects women and men's life expectancy as an indicator of health. The Human Development Report Index figures give life expectancy from birth for South Africa of 50.8 years and 78.3 for Chile. The Global Gender Gap Report 2008 country profiles give lower figures: women and men have a life expectancy of 45 and 43 years respectively,

- compared with 70 and 65 for Chile (see Dayal, 2009).
2. It is estimated that 23 407 South African doctors are in Australia, New Zealand, Canada, United Kingdom, and the United States (Naicker *et al*, 2009).
 3. The Conference was held in Gallagher Estate from 27-30 June 2007.
 4. The NHI Policy Paper is available at: <http://www.info.gov.za/view/DownloadFileAction?id=148470>.
 5. See UN CESCR General Comment No. 14 The right to the highest attainable standard of health (2000) para 12.
 6. The CESCR was adopted by the UN General Assembly on 16 December 1966. It entered into force on 3 January 1976. See article 12.
 7. The CEDAW was adopted in December 1979. It entered into force on 3 September 1981. See article 12.
 8. The treaty was adopted in Maputo in July 2003 and entered into force 25 November 2005. See article 14.
 9. See CEDAW General Recommendation No. 24: Women and health (UN, 1999).
 10. See CESCR General Comment No. 14: The right to the highest attainable standard of health (UN, 2000).
 11. See CESCR General Comment No.14: The right to the highest attainable standard of health (UN, 2000), para 12 (a–d).
 12. 'Ratification' is an act by which a state signifies an agreement to be legally bound by the terms of a particular treaty. To ratify a treaty, the State first signs it and then fulfils its own national legislative requirements. Once the appropriate national organ of the country – Parliament, Senate, the Crown, Head of State or Government, or a combination of these – follows domestic constitutional procedures and makes a formal decision to be a party to the treaty. The instrument of ratification, a formal sealed letter referring to the decision and signed by the State's responsible authority, is then prepared and deposited with the United Nations Secretary-General in New York (UN, 1990).
 13. 'Accession' is an act by which a state signifies its agreement to be legally bound by the terms of a particular treaty. It has the same legal effect as ratification, but is not preceded by an act of signature. The formal procedure for accession varies according to the national legislative requirements of the state. To accede to a human rights treaty, the appropriate national organ of a state – Parliament, Senate, the Crown, Head of State or Government, or a combination of these – follows its domestic approval procedures and makes a formal decision to be a party to the treaty. Then, the instrument of accession, a formal sealed letter referring to the decision and signed by the State's responsible authority, is prepared and deposited with the United Nations Secretary-General in New York (UN, 1990).
 14. The relationship between international law and South African constitutional law was affirmed in the case of *Kaunda v President of the Republic of South Africa* 2005 (4) SA 235 (CC) (Paras 221-222).
 15. See CESCR General Comment No.14: The right to the highest attainable standard of health (UN, 2000), para 9.
 16. The centrality of PHC was more clearly outlined by the WHO in the international conference on PHC held in Alma Ata, Kazakstan in 1978.

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