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PRESSING AHEAD WITH NHI IMPLEMENTATION

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SYNOPSIS

There is still no clarity on what the proposed National Health Insurance (NHI) system will cost, how it will be financed, how the supply of health services can be ramped up to match increased demand, how the enormous administrative burden will be met, or how the corruption the new system will foster can be curbed. In March 2017 the Davis Tax Committee also warned (in a report which it finally made public last week) that the NHI was 'unlikely to be sustainable unless there was sustained economic growth'. The government is nevertheless busily pressing ahead with NHI implementation.

A revised NHI White Paper

A revised White Paper on the NHI was gazetted by the health minister, Dr Aaron Motsoaledi, on 30th June 2017. This revised document is much the same as a draft white paper, published in December 2015, which was widely criticised by experts for the many weaknesses in what it proposed.

NHI benefits

The White Paper gives a long list of the services the NHI is to provide free of charge to all South Africans. These range from cardiology, dermatology, and neurology to oncology and cancer treatments, psychiatry, obstetrics, gynaecology, paediatrics, orthopaedics, and surgery (including organ transplants of various kinds). At the primary health care level, the services to be provided will include 'sexual and reproductive' health care, along with optometry, 'oral health rehabilitation', and a comprehensive range of remedies for

> *If health spending keeps increasing at 9% a year, then NHI costs are likely to rise from R665bn in 2025 (13% of GDP) to R2 030bn (equivalent to roughly 30% of likely GDP) in 2040.*

mental disorders and disability needs. Treatment for 'rare diseases' and 'dread diseases' will also be provided, along with comprehensive radiology services, including 'nuclear medicine and radiation oncology'.[1]

NHI costs

The White Paper again fudges the key question of what the NHI is likely to cost. Instead of trying to provide any realistic estimate, the document simply repeats the figures provided in the December 2015 draft. It thus puts 'projected NHI expenditure' in 2025/26 (when the new system is supposed to be fully operative) at R256bn in 2010 prices.

However, if both public and private spending on health care in the current financial year is taken as the starting point and the health inflation rate is estimated at 6% a year, then the NHI will cost R665bn in 2025, rising to R890bn in 2030, R1 190bn in 2035, and R1 260bn in 2040.

But health inflation is in fact higher than 6%. In nominal terms, expenditure on public health care has gone up by roughly 45% over the past five years or by 9% a year on average. Spending on private health care has gone up by much the same proportion over this time.[2]

If health spending keeps increasing at 9% a year – and the NHI proposal offers no meaningful way of bringing it down – then NHI costs are likely to rise from R665bn in 2025 (13% of GDP) to R965bn in 2030, R1 400bn in 2035, and R2 030bn (equivalent to roughly 30% of likely GDP) in 2040. Spending of this magnitude on health care within a scant 15 years of the system's introduction is completely unaffordable.

NHI financing

Like its predecessor, the White Paper presumes that only R72bn in additional revenue will be needed to fund the NHI. It also claims that this sum could be raised through a 4% surcharge on taxable income. However, actual costs are likely to be far higher, which means that the tax increases required will be much larger too.

At the same time, the White Paper overlooks the small size of South Africa's tax base. Though some 18 million employees were registered for personal income tax in 2015, most had earnings below the tax payment threshold. Hence, 62% of all personal income tax that year was paid by some 560 000 people with annual taxable income of R500 000 or more. If increased taxes and reduced health services were to encourage 250 000 of these individuals to emigrate, the personal income tax that could be collected would be reduced by more than a quarter.[3] This would make it all the more difficult to sustain social grants and free services for the poor.

In addition – and even without the NHI – the fiscus faces a revenue shortfall of R51bn in the current financial year, rising to a cumulative R209bn over the next three years (as the October 2017 medium-term budget policy statement has acknowledged). Public debt will soon more than quintuple, rising from R630bn in 2008/09 to R3.4 trillion in 2021/22. Interest payments – even without the further ratings downgrades that surely lie ahead – will then amount to R223bn, or some R610m a day.

The NHI Fund

The White Paper claims that the NHI will significantly reduce healthcare costs by introducing 'a single-payer and single-purchaser fund', which will 'leverage its monopsony power'[a] to 'strategically' purchase services and achieve major 'economies of scale'.[4]

However, monopsony power will be less important than state regulation, for the NHI will also give the Department of Health control over all prices, ranging from the cost of aspirin and rubber gloves to the fees payable to surgeons and GPs. The document assumes that these controls will be effective in cutting costs and enhancing quality. But the more likely outcome is that many valuable therapies, health technologies, and diagnostic tests will be ruled out as too costly.

In addition, no amount of 'strategic' purchasing by a centralised fund will address the major drivers of health care costs. These are increasing utilisation rates resulting from an ageing population, high levels of chronic disease, and the rising costs of new medicines and technologies, compounded by the falling value of the rand.

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The bureaucratic burden of the NHI

The NHI Fund will be buttressed by 12 'specific technical functional units', ranging from 'a Planning and Forecasting Unit' to 'a Procurement Unit', a 'Provider Payment Unit' and a 'Risk and Fraud Prevention Unit'. A host of other committees, at both national and district levels, will also be required to oversee and co-ordinate the system.

The White Paper, like its 2015 predecessor, makes no attempt to quantify the costs of this bureaucracy. Its estimate of the R256bn the NHI will cost in 2025 also overlooks these expenses. Yet all these new administrative entities will have to be suitably staffed, remunerated, equipped, and provided with appropriate office or other working space.[5]

Fraud and corruption

The lodging of fraudulent claims against medical schemes is already a major problem costing the industry some R22bn a year. According to the Board of Healthcare Funders, 'at least 7% of all medical claims in South Africa are fraudulent and the figure could be as high as 15%'. Under the NHI, South Africa is likely to lose very much larger sums to fraudulent claims unless effective steps are taken to prevent this.[6]

Fraud and inflated pricing in public procurement are also already rife. As Kenneth Brown, chief procurement officer at the National Treasury, warned in October 2016, some 40% of the government's R600bn

a A monopsony arises where one buyer interacts with many would-be sellers and thus has considerable market power.

budget for goods and services – amounting to roughly R240bn a year – is currently tainted by 'inflated prices and fraud'.[7] Unless this trend can be reversed, the hundreds of billions of rand in the procurement budget of the NHI Fund are likely to be similarly compromised.

Major inefficiency within the NHI Fund

Even if fraud and corruption can be countered, the problem of inefficiency is likely to remain. If the NHI Fund is anything like other state monopolies – Eskom, Transnet, Prasa, Portnet, and the South African Post Office – its administration will be grossly flawed and ineffective.

The example of the (workmen's) Compensation Fund is also relevant here. The Fund receives some R11bn a year in mandatory contributions and pays some 900 000 claims a year to doctors for treating people injured at work. Often, however, doctors have to wait a year or more to be paid.

In 2015 a survey carried out by the South African Medical Association (SAMA) among medical practitioners in Gauteng found that 65% of them had been adversely affected by the Fund's failure to pay their claims. The average amount outstanding was R895 000 per doctor, said SAMA. The DA commented that 'these figures were astronomical and could easily result in small medical practices having to shut their doors'.

Similar problems are evident at the Compensation Commission for Occupational Diseases, which is supposed to provide compensation to mineworkers suffering from lung diseases contracted on the job. In July 2017 the Commission had an estimated backlog of some 700 000 unpaid claims, including some 94 000 claims which had already been approved for payment by the Medical Bureau for Occupational Diseases.

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A similar story is evident at the Road Accident Fund (RAF), which is funded by the fuel levy and is supposed to pay the claims of people injured in road accidents. The RAF receives a monthly income of about R3bn and makes some 30 000 payments a month. But the RAF also has a backlog of roughly 5 600 claims, cumulatively worth around R8.4bn. Court-ordered deadlines for payment are so often ignored that 'more than 1 000 warrants of execution are received from sheriffs every month...and it is common for RAF assets to be attached, removed, and sold,' as the organisation acknowledged in February 2017.[8]

The gross inefficiencies at the Fund, the Commission, and the RAF provide some indication of the problems likely to arise under the NHI. Those problems are likely to loom even larger, as the NHI Fund will have a budget of at least R256bn a year, compared to R11bn for the Fund and R36bn for the RAF. Moreover, instead of having to deal with only small groups of South Africans, the NHI Fund will be responsible for all the health services provided by all accredited hospitals, clinics, doctors, specialists, nurses, and other health providers to some 56.6 million South Africans. It will also have to take charge of all the medicines, medical devices, diagnostic tests, consumables, and other relevant goods and services that may be supplied to the population in any given year. The three funds earlier described have failed to deal effectively with a far smaller number of claims. Imagine, then, the inefficiency and inordinate delays that are likely to arise once the NHI Fund has to start overseeing and paying out on hundreds of millions of claims each year.

Certification and accreditation for NHI participation

All health providers and facilities, whether public or private, that wish to participate in the NHI will first have to be assessed and certified by the Office of Health Standards Compliance (OHSC). Once OHSC certifica-

tion has been obtained, the Accreditation Unit of the NHI Fund will decide whether accreditation should follow.

How many health providers or facilities will qualify for certification by the OHSC remains uncertain. At present, however, most public clinics and hospitals would not be able to take part in the NHI as their compliance with core norms and standards is too low. In 2014/15, for example, the OHSC inspected 417 out of roughly 3 900 state facilities and found that only 3% of them were 'compliant'. Another 13% were compliant 'with requirements' or were 'conditionally compliant'. The remaining 84% were non-compliant, of which 16% were 'conditionally compliant with serious concerns', 28% were 'non-compliant' and 40% were 'critically non-compliant'.[9]

Compliance standards have generally deteriorated since then, especially at the primary level which will be crucial to the NHI. Between 2012 and 2016, compliance among the clinics and community health centres assessed edged up by a single percentage point in two provinces: in Mpumalanga (where it rose from 47% to 48%) and in the Northern Cape (where it went up from 40% to 41%). But compliance diminished in all other provinces, including Gauteng and the Western Cape. Moreover, whereas in 2012 four provinces had compliance scores above 50%, in 2016 only Gauteng came in above the 50% level with a score of 55% (down from 69% in 2012).[10]

The role of medical schemes

South Africa has a world-class system of private health care, to which some 30% of its population on average, or roughly 17 million people, have access through their medical schemes, health insurance policies, or out-of-pocket payments. In the 2017/18 financial year, spending on private health care is expected to amount to R213bn, of which 83% (R177bn) will go to medical schemes, while R29bn will be spent on out-of-pocket expenses, and R5bn will go to health insurance. South Africa's 82 medical schemes are thus vital in providing access to private health care.[11]

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The number of people belonging to medical schemes has risen from 6.9 million in 1997 to 8.9m in 2016. However, because the South African population has also increased over this period, medical scheme membership as a proportion of the total population has remained much the same, at around 16%. The demographic representation of medical schemes members has nevertheless changed substantially over the years, for 49% of members are now black Africans, while 10% are coloured, 7% are Indian and the remaining 34% are white.[12]

Despite this major shift, the government plans to use the NHI to put an end to almost all medical schemes. According to the White Paper, 'individuals will not be allowed to opt out of making the mandatory prepayment towards NHI, though they may choose not to utilise NHI healthcare services.'[13] This in itself could bring about the demise of most medical schemes, as most medical scheme members will battle to afford both their medical aid contributions and the additional taxes required to fund the NHI.

Medical schemes will also be confined to 'offering complementary cover to fill gaps in the service coverage offered by the NHI'. Restricting medical schemes in this way is likely to sound their death knell. A medical scheme could still cover a rare disease such as haemophilia (uncontrollable bleeding), if this was excluded from the NHI package. But the pool of potential members wanting cover of this kind would be very small. Premiums would thus have to be set so high that only the very rich could afford them.[14]

Few, if any, medical schemes will survive in these circumstances. The main source of funding for private health care will thus mostly come to an end. Some private practices might still be able to continue on a cash

basis, but most will struggle to survive – especially as many of their potential patients will also be paying high payroll and income taxes to help fund the NHI.[15]

Pushing ahead with implementation

New committees being established

On 7th July 2017, a scant week after the gazetting of the White Paper, the Department of Health gazetted details of the 'institutions, bodies and commissions' that must be established to help implement the NHI.[16]

All these new institutions are to be established under Section 91(1) of the National Health Act of 2003, which empowers the minister to establish such 'advisory and technical committees as may be necessary to achieve the objects' of the statute. However, these objects make no mention of the NHI. The establishment of the proposed bodies is thus *ultra vires* the Act (beyond the powers conferred by the statute) and prima facie unlawful.[17]

The new committees will be responsible, among other things, for developing clinical guidelines and 'rationing criteria' for tertiary care; recommending the fees to be paid to doctors, specialists, and hospitals; and establishing an agency to decide on the health technologies to be allowed under the NHI. One committee has also been instructed to consider the introduction of mandatory medical scheme membership for employees. However, if this is in fact permitted – which seems unlikely – it will be nothing more than 'an interim measure on the path to the NHI', says the Department of Health.[18]

The NHI Fund

Legislation to establish the NHI Fund is currently being developed. The present tax credit for medical scheme membership may also be reduced (as described below) to help finance the NHI Fund. The Fund will start by focusing on maternal health care and the provision of spectacles and hearing aids to school pupils, among other things.

> *Government regulation has already greatly pushed up the costs of medical scheme membership through arbitrary reserve requirements, an insistence on open enrolment and community rating, the introduction of some 300 'prescribed minimum benefits' (PMBs), and a bar on low-cost medical schemes that could have extended medical aid membership to 15 million more people.*

Further interventions against private health care

Earlier interventions

Government regulation has already greatly pushed up the costs of medical scheme membership through arbitrary reserve requirements (set at 25% of annual contributions); an insistence on open enrolment and community rating, which makes it hard to attract the young and healthy; the introduction of some 300 'prescribed minimum benefits' (PMBs) which have to be paid for 'in full'; and a prohibition on low-cost medical schemes that might otherwise have extended medical scheme membership to some 15 million more people.

Current moves against medical schemes

Ending the tax credit

According to the White Paper, current tax credits for medical scheme membership are to be removed and used to fund the NHI. At present, the tax credit reduces the amount of personal income tax that taxpayers belonging to medical schemes must pay. It results in the revenue service collecting some R20bn a year less than it might otherwise do.[19]

The rationale for the tax credit is that it encourages people to join medical schemes, so increasing the use of private health care and reducing the burden on over-stretched public facilities. But Dr Motsoaledi

claims that the tax credit is illegitimate because 'the money…is sent to people who are already rich, [when it should be used] to help those who are poor'.[20]

However, the National Treasury has since found that these tax credits are 'well-targeted to lower- and middle-income taxpayers', as finance minister Malusi Gigaba noted in his recent medium-term budget policy statement. In the 2014/15 tax year, for instance, more than half (56%) of the total credits claimed went to 1.9 million taxpayers with annual taxable incomes below R300 000. Removing the tax credit would make it difficult for these households to retain their medical scheme membership – which is why the Treasury now wants to give the matter more thought.

Removing public sector subsidies

The health minister is also intent on removing the subsidies the government currently provides to millions of public servants to help them pay their medical scheme contributions. Most public servants belong to state schemes, such as the Government Employees Medical Scheme (GEMS), but some also belong to private schemes. Overall, these subsidies cost the fiscus an estimated R27bn a year.[21]

However, public sector unions have campaigned long and hard for these subsidies, while their removal would reduce the benefits provided to public servants by between R24 200 and R61 000 a year.[22] In practice, union members may thus object to the termination of these subsidies, irrespective of what their leaders might say.

One benefit option only

In 2016, open medical schemes had an average of 6.5 benefit options per scheme, while restricted schemes (where membership is confined to employees, for instance) generally had two. Now, however, medical schemes are to be confined to offering only a single benefit option.

> *Dr Motsoaledi remains adamant that, once the NHI has been rolled out, the medical schemes that remain will 'all be collapsed into a single state-run medical aid plan'. But ordinary public servants 'don't want to find themselves in a situation where the NHI is the only option.'*

The White Paper provides no clarity as to what this single option should cover. The director general of health, Dr Precious Matsoso, has said that 'the prescribed minimum benefits (PMBs) are to be replaced with a comprehensive set of services', to which all medical scheme members will be entitled. But medical schemes may battle to provide this comprehensive single package if their membership numbers start to dwindle as current tax credits and state subsidies are removed. The proposal also ignores the extent to which the low-income plans currently offered by many open medical schemes are subsidised by mid- to high-end plans.[23]

Consolidation of medical schemes

According to the White Paper, the government will identify all the funding for medical schemes which it currently provides and then 'consolidate' this into the NHI Fund. More recently, however, the minister has indicated that a different kind of consolidation is also envisaged. Smaller state medical schemes will be 'consolidated' into GEMS, while smaller private medical schemes will be 'folded' into larger ones. However, it remains unclear how this is to be achieved, or what the legal and constitutional ramifications of these changes might be.[24]

Dr Motsoaledi remains adamant that all medical schemes will 'eventually be gone', once the NHI is in operation. 'This will be a process that takes years and, in the transition, there will be consolidation', he says. Once the NHI has been rolled out, the medical schemes that remain will 'all be collapsed into a single state-run medical aid plan', he states.[25] But ordinary public servants are worried about this idea, a spokesman for the Public Servants' Association saying that officials 'don't want to find themselves in a situation where the NHI is the only option.'[26]

Curtailing health insurance

On 23rd December 2016, in the midst of South Africa's festive season, the Department of Health and the National Treasury gazetted regulations aimed at limiting access to health insurance products of various kinds. These regulations are known as 'demarcation' regulations because they demarcate or identify health insurance products which the government wants to have treated as medical schemes. The demarcation regulations generally took effect on 1st April 2017.[27]

The demarcation regulations have particular impact on primary health care policies. In return for premiums ranging from R90 to R300 a month, these policies generally entitle people to a limited number of GP consultations, some acute and chronic medication benefits, and basic radiology, dentistry, pathology, and optometry benefits. These policies are particularly popular with lower-income households unable to afford the high costs of medical schemes.

Under the demarcation regulations, however, new primary health care policies have been prohibited since 1st April 2017, while existing policies may be exempted until April 2019. By then, low-cost medical scheme options are supposed to have been developed, but it remains doubtful whether this will be done.[28]

The principal effect of the demarcation regulations, once they come fully into effect, will be to deprive some 2 million people with primary insurance policies of access to private health care. In the words of Richard Blackman, CEO of Day1 Health: 'People take up primary health care insurance because they want to access private health care but can't afford the conventional medical aid premiums... Now, the government is taking that right away from them and forcing them either to pay for medical aids or use the public health care sector. What is tragic is that the cheapest medical scheme options cost [at least] three times as much as what primary health care insurance policies cost.'[29]

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Stigmatising private health care

The ANC is ideologically hostile to business and has long demonstrated a deep suspicion of the 'profit' motive in private health care. Both for this reason – and to help pave the way for its damaging regulatory interventions – it has repeatedly stigmatised the private health care system as costly, selfish, and uncaring in its constant drive to put 'profits before people'.

Stigmatisation has continued in 2017, with the minister constantly repeating the same unfounded accusations against the private healthcare system. According to the minister, the private system has been 'systematically stripping' the public healthcare sector of key resources. The private system also devotes a massive 4.4% of GDP to meeting the health needs of a mere 16% of South Africans. At the same time, he claims, the private sector lures specialists away from the public service, with the result that only '20% of all specialists are left to serve 84% of South Africans'.[30]

However, there are many fallacies in the minister's analysis. As earlier noted, some 62% of personal income tax is paid by some 560 000 people, most of whom get little back from the fiscus. Private health care is funded from people's after-tax salaries and does not infringe on the resources available to the public sector. Those resources amount to 4% of GDP, which compares well with other emerging markets. The key problem, however, is that available tax revenues are often badly used because of limited skills, poor management, and widespread financial irregularities in the public healthcare sector.[31]

It is also inaccurate to assert that the private health system serves only 16% of the population, when some 30% of South Africans on average rely on private practitioners: 16% of them through their medical schemes and 13% by making out-of-pocket payments as the need arises. In addition, more detailed

utilisation figures show that 62% of South Africans rely on public sector nurses, while 38% rely on private sector ones. Similarly, 63% of the population consult public service GPs, while 37% use those in the private sector.[32]

Alternatives to the NHI proposal

In the past year, Dr Motsoaledi has frequently accused critics of the NHI of wanting to retain an unfair system and deprive South Africans of the benefits of universal health care (UHC). This accusation is false. It is not the UHC goal that critics oppose, but rather the inability of the NHI to achieve it. Critics also point to the folly of insisting on the NHI as the only way to proceed when better alternatives are readily available.

Concrete proposals for a new UHC system – that would be fully in line with what the World Health Organisation (WHO) recommends – have been developed by the South African Private Practitioners' Forum (an organisation representing private specialists), the Democratic Alliance, the Free Market Foundation, and the IRR, among others.

All agree that the most important need is to give the poor increased access to South Africa's world-class system of private health care. Such access should be financed by the government, either through state-funded vouchers or by some variant of these. Affordability should be increased by allowing low-cost medical schemes and primary health insurance products, and by either returning to risk rating (the most cost-effective option for most people) or introducing risk equalisation between medical schemes. Medical scheme membership and/or health insurance cover should be mandatory for all employees, with premiums for lower-paid employees buttressed by employer contributions for which businesses should garner tax credits. Once millions of South Africans are empowered in this way, medical schemes and health insurers will have to compete for their custom, helping to encourage innovation and contain costs.

The most important need is to give the poor increased access to South Africa's world-class system of private health care. Such access should be financed by the government, either through state-funded vouchers or some variant of these. Affordability should be increased by allowing low-cost medical schemes and primary health insurance products, and by either returning to risk rating or introducing risk equalisation.

All these organisations also urge that the efficiency of public hospitals and clinics be greatly enhanced. This requires merit-based appointments, strong internal discipline and accountability for performance, and effective action against corruption and inflated pricing. In the short term, it also requires sound public-private partnerships, with the administration of health facilities contracted out to private firms through open and competitive tendering processes.

The proposals also concur in stressing that the supply of health facilities and health providers must be significantly increased. Current regulatory constraints must be removed so that the private sector can more easily establish day hospitals and other health facilities. Private institutions could then also start training the doctors, nurses, specialists, and other providers the country so badly needs.

A warning from the Davis Tax Committee

In March 2017 the Davis Tax Committee, in a report on the financing of the NHI, warned that 'substantial increases' in VAT or personal income tax, or the introduction of a new social security tax, would be needed to fund the NHI. It also said (emphasis as in the original) that *'the proposed NHI, in its current format, is unlikely to be sustainable unless there is sustained economic growth'*. It further cautioned that 'the magnitudes of the proposed NHI fiscal requirements are so large that they might require trade-offs with [ie reductions in] in other laudable programmes', such as increased funding for post-school education or 'social security reform'. Yet the comprehensive benefits promised by the NHI were unlikely to be achieved, as a 2015 World Bank report on universal health coverage in 24 developing countries had found that there was generally 'a gap between the free comprehensive benefit package promised...and the de facto actual benefits'.[33] (The

committee's report was released only in mid-November 2017, as this paper was being prepared for publication. Its key findings are thus set out in the *Stop-Press Section* which follows.)

Time for an affordable, constitutional, and workable alternative

The true objectives behind the NHI are not to improve access to health care but rather to increase the power and control of the ruling ANC. Part of the aim is to push the private sector out of a key sphere and increase dependency on the state. This will also weaken the middle class, as many wealthier South Africans may choose to emigrate rather than be forced to rely on the inefficient health services that will remain. The more the middle class erodes, the more this will strengthen the ANC's hold on power, as middle-class voters are the ones most likely to shift to rival parties. Giving a greatly expanded army of bureaucrats ever more control over the pricing and provision of health care will also increase the ANC's powers of patronage, while generating many opportunities for individual enrichment too.

A critical part of the ANC's objective is to use the NHI to advance the national democratic revolution (NDR). Both the ANC and its communist allies have been committed to the NDR since the 1960s, for they see it as offering an incremental but 'direct' way to take South Africa from a predominantly capitalist economy to a socialist and then communist one. Putting an end to private health care and vastly empowering the state will, of course, serve this ideological aim. But empowering the state in this way will also open up many opportunities for self-enrichment for a small political elite, who are becoming increasingly aware of how NDR goals can be harnessed to their own kleptocratic and selfish ends.

Putting an end to private health care and vastly empowering the state will serve ideological aims. But empowering the state in this way will also open up many opportunities for self-enrichment for a small political elite, who are becoming increasingly aware of how NDR goals can be harnessed to their own kleptocratic and selfish ends.

If South Africa is to attain the benefits of economic growth, rising employment and expanding prosperity, the ANC's outdated and damaging NDR ideology must be jettisoned. So long as the ruling party remains intent on pursuing a socialist and communist future, investment will be muted, growth limited, and unemployment high. This dismal situation is also precisely where South Africa now finds itself, as Mr Gigaba's medium-term budget policy statement has so graphically shown.

However, even in its current straitened circumstances, the country could still implement a new UHC system which would be affordable, constitutional, and effective in meeting health needs. At the same time, if this initial UHC system is to keep improving the benefits it offers to a growing population, the annual growth rate must rise to at least 5% of GDP a year so that millions more jobs are generated and the tax base can expand.

All these gains can yet be achieved. However, they will become increasingly unattainable if the ANC continues to propel the country down the NDR path. This outdated ideology – which even its Soviet authors have long since abandoned – must thus be jettisoned, along with the NHI proposal it has helped to spawn.

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STOP PRESS: THE DAVIS TAX COMMITTEE'S REPORT ON THE FINANCING OF THE NHI

A report by the Davis Tax Committee (DTC) on the financing of the NHI stresses the need for much more detailed costing information. It also warns that the NHI will require major tax increases, and will not be sustainable without much faster economic growth. The DTC's report has also been available to the government since March 2017 (though it was released to the public only last week). Yet health minister Dr Aaron Motsoaledi seems to have ignored all the salient concerns raised by the DTC in gazetting a final White Paper in June 2017 and otherwise pushing ahead with NHI implementation.

Introduction

The Davis Tax Committee (DTC) was established in 2013 by the minister of finance to inquire into the role of the tax system in promoting inclusive growth, employment creation, development, and fiscal sustainability. It is also required to evaluate funding proposals for major interventions, such as the proposed National Health Insurance (NHI) system.

In October 2016 it called for submissions on the NHI funding proposals set out in a draft white paper gazetted for comment in December 2015. The DTC finalised its report on the financing of the NHI in March 2017. Hence, though its assessment was made public only on 13th November 2017,[1] it has been available to the government for the past seven months or so. Yet the many salient warnings in the DTC's report have been ignored by health minister Dr Aaron Motsoaledi in gazetting the final White Paper in June 2017 and otherwise pressing ahead with NHI implementation.

> *'Realistic costing on a well defined benefit basket is critical for assessing fiscal consequences, sustainability, and revenue raising requirements', the DTC said. Yet the final White Paper gazetted in June 2017 continues to insist that 'focusing on "what will NHI cost" is the wrong approach'.*

Key warnings from the DTC report

Detailed costing required

The DTC report stresses that no realistic assessment of the NHI financing need can be developed without comprehensive information on the benefits to be covered, the administrative costs to be incurred, likely rates of health inflation, and a host of other issues. But the draft white paper of December 2015 showed 'substantial uncertainty' on all these issues and lacked the 'detailed implementation...and financing plans' needed. However, 'realistic costing on a well defined benefit basket is critical for assessing fiscal consequences, sustainability, and revenue raising requirements', the DTC said.[2]

The final White Paper gazetted in June 2017 ignores these important comments. Instead, it continues to insist that 'focusing on "what will NHI cost" is the wrong approach', as it is likely to 'require an endless cycle of revisions and attempts to dream up new revenue sources'.[3] That, however, is precisely the point. New revenue sources cannot be 'dreamt up', which means that 'realistic costing' is vital before the viability of the NHI can be assessed.

According to the DTC report, the funding assumptions in the draft white paper are also unrealistic. They understate the likely costs of the NHI and over-estimate likely future annual growth rates, putting these at

3.5% of GDP. Annual costs could thus be 'substantially higher', the DTC cautions, while projected revenue shortfalls, which are 'highly sensitive to the growth rate', could be much bigger.[4]

Again, the final White Paper ignores these warnings. Instead, it simply repeats the funding figures contained in the 2015 draft, which in turn repeat the 2010 data used in the 2011 green paper on the NHI. That green paper promised that the white paper that was still to come would incorporate a full NHI costing provided by the Treasury.[5] However, that promise has never been fulfilled. Instead, the same increasingly outdated and unrealistic figures continue to be recycled – even though the DTC report has strongly reinforced the need for accurate data and proper financial planning.

Big populist promises, but little public consultation

The DTC report cautions that the NHI promise of comprehensive free health services is unlikely to be met. Here, it cites a 2015 report by the World Bank, which analyses the experience of 24 developing countries in implementing universal health coverage, and says: 'In many developing countries, there is a gap between the free comprehensive benefit package promised, without any restrictions in theory, and the de facto actual benefits.' What happens in practice is an 'implicit rationing', which balances increased demand for health services against the resources that are in fact available. This rationing is commonly reflected in 'long waiting times', 'stock outs of critical drugs' and other 'quantitative restrictions by health care providers'. Moreover, 'the burden of [this] implicit rationing tends to fall most heavily on the poor and vulnerable'.[6]

Again, however, the final White Paper ignores the DTC report and the World Bank experience on which it draws. Instead, the White Paper continues to paint a glowing (and fundamentally misleading) picture of the comprehensive benefits the NHI will supposedly provide to each of 55.6 million South Africans.

> *The DTC's report warns that 'inadequate consultation at the early stages of NHI may well create resistance to change in the later stages of implementation – much like the e-tolls'. It further warns that 'the voice of the person in the street, the patient, seems conspicuous by its absence.*

The DTC's report also talks about the need for proper public consultation, saying 'inadequate consultation at the early stages of NHI may well create resistance to change in the later stages of implementation – much like the e-tolls'. It further warns that 'the voice of the person in the street, the patient, seems conspicuous by its absence in a policy domain dominated by experts'.[7]

This concern has likewise been brushed aside. No effective mechanism has been put in place to garner the views of ordinary South Africans. The Department of Health also seems to have little interest in expert views, for hundreds of submissions highlighting the many problems in the green paper and the 2015 draft have simply been ignored in the final White Paper.

The future of medical aids

The DTC report fudges the key issue of what is to happen to medical aids when the NHI takes effect. It seems unwilling to accept that the NHI will put an end to most of them. Instead, it assumes that 'higher income earners' will be able to 'retain private medical cover, despite mandatory contributions to NHI' – and suggests that many might choose to do so if they were dissatisfied with the quality and range of NHI benefits.[8]

Based on this flawed assumption, it adds that 'a great deal of the economic and fiscal impact depends on the shift from private to public financing, the role of private medical funds,...and the regulation of health care'. It does, however, sound an oblique warning that the middle class may not be satisfied with NHI options and that 'the highest earners are also the most internationally mobile.'[9]

Here, however, the DTC report overlooks the clear statement in the 2015 draft that medical schemes are

to be confined to providing cover that 'complements', rather than duplicates, the benefits available under the NHI.[10] This means that medical schemes will be confined to providing cover for rare diseases, advanced dentistry, or cosmetic surgery, which few people will want. Most medical aids will be compelled to close, turning the NHI into a state monopoly on which almost all South Africans will be forced to depend.

Such an outcome could well prompt emigration by the best skilled and most 'mobile' South Africans. This in turn would have major ramifications for South Africa's tax base and hence for 'the economic and fiscal impact' of the NHI, as the DTC report hints. The DTC report could and should have been more candid on the risks in this regard. But that the final White Paper simply ignores its veiled warning suggests wilful blindness on the minister's part.

Possible taxes and overall sustainability

The DTC highlights some of the key challenges here. The report notes that the tax base in South Africa is very narrow, while unemployment is high. South Africa thus cannot rely on the social security taxes used in most Organisation for Economic Cooperation and Development (OECD) countries to help finance universal health coverage, as these taxes link benefits received to contributions made.[11]

The report adds the NHI will 'result in a structural increase in spending'. This, it says, means that the taxes used to fund it must be 'sufficiently buoyant to yield a structural increase in revenues of the appropriate magnitude'. These taxes should also have 'as broad a base as possible', so that increases in rates can be smaller and less distortive. Hence, the possibility of hiking VAT to help pay for the NHI should not be ruled out, the DTC concludes. However, the revised White Paper ignores this view in discounting VAT as a funding option.[12]

The DTC report also stresses that 'the pace of [NHI] implementation must be consistent with the fiscal resource envelope'. Ideally, it adds, 'there should be a fiscal rule to link NHI spending with the availability of fiscal resources'. To reinforce this point, the report also states (emphasis as in the original):[13]

> *The DTC report says 'substantial increases in VAT or personal income tax and/or the introduction of a new social security tax would be required to fund the NHI'. It adds that 'the proposed NHI, in its current format, is unlikely to be sustainable unless there is sustained economic growth'.*

- that '*substantial increases in VAT or personal income tax (PIT) and/or the introduction of a new social security tax would be required to fund the NHI*';
- that 'the magnitudes of the proposed NHI fiscal requirements are so large that they might require trade-offs with other laudable...programmes such as expansion of access to post school education or social security reform'; and
- that '*the proposed NHI, in its current format, is unlikely to be sustainable unless there is sustained economic growth*'.

Again, however, the White Paper simply ignores all these concerns. Instead of engaging with them, the minister has chosen rather to pretend that these important warnings against the NHI have not been issued.

Economic deterioration since the DTC's report

South Africa's economic situation has deteriorated sharply since March 2017, when the DTC finalised its NHI report. At that time, Pravin Gordhan was still finance minister and the country had at least a reasonable prospect of warding off ratings downgrades. Its position is now much worse. Mr Gordhan has been axed, two international ratings agencies have downgraded its foreign debt to sub-investment (junk), the institutional strength of the National Treasury and the South African Revenue Service has been undermined, and the leaked Gupta e-mails have for months been providing ever more evidence of the extent of 'state capture' and corruption in vital ministries and state-owned enterprises.

The damage that has been done is at least partially reflected in the medium term budget policy statement released by Mr Gordhan's successor, Malusi Gigaba, in October 2017. This warns that revenue shortfalls will total R209bn over the next three years, that public debt will rise to 60% of GDP in 2021/22, and that interest payments will then – even without the further rating downgrades that now clearly loom – amount to R223bn or R615m a day.

Back in March 2017, the DTC report effectively identified the NHI as unaffordable and unsustainable. South Africa's financial situation is now so much worse that the only sensible course is to scrap the NHI and find much better ways of implementing UHC. The key question, however, is whether the health minister and other ideologues – who have simply ignored the DTC's report in pressing ahead with NHI implementation – will be willing to reconsider. If not, South Africa will pay a heavy price for an NHI experiment that risks destabilising the health care system and could be catastrophic for the country.

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PRESSING AHEAD WITH NHI IMPLEMENTATION

There is still no clarity on what the proposed National Health Insurance (NHI) system will cost, how it will be financed, how the supply of health services can be ramped up to match increased demand, how the enormous administrative burden will be met, or how the corruption the new system will foster can be curbed. The government is nevertheless busily pressing ahead with NHI implementation.

A final white paper on the NHI has been published, NHI committees are being established, and the mooted NHI Fund is soon to be set up. To help clear the way for the NHI, access to private health care is increasingly being limited by the state's own regulations. New primary health insurance policies have already been prohibited, while the tax credit for medical scheme membership may soon be removed. Smaller medical schemes are to be 'folded' into larger ones, while all medical schemes will have to narrow the cover they offer down to a single option. To justify these interventions, the stigmatisation of the private health sector persists. So too does the health minister's false claim that the NHI offers the only way to achieve universal health coverage in South Africa, when clearly this is not so.

A revised NHI White Paper

A revised White Paper on the NHI was gazetted by the health minister, Dr Aaron Motsoaledi, on 30th June 2017 (the White Paper). The public was not invited to make comments on this amended document, which has been approved by the Cabinet and presented to the nation as a fait accompli.[1]

A revised white paper on the NHI was gazetted by the health minister, Dr Aaron Motsoaledi, on 30th June 2017. The public was not invited to make comments on this amended document, which has been approved by the Cabinet and presented to the nation as a fait accompli.

This revised document is much the same as a draft white paper, published in December 2015, which was widely criticised by experts for the many weaknesses in what it proposed. The revised white paper fails to address these problems. Like its predecessor, the current document makes no attempt to clarify what benefits the NHI will provide; how much the new system will cost; what tax increases will be needed to cover these costs; how large, inefficient, and corrupt the new NHI bureaucracy is likely to be; how poor standards of health care in the public sector are to be improved; and how the enormous demand for health services that the NHI will trigger can realistically be met.

NHI benefits

As the White Paper reaffirms, the proposed NHI system is intended to 'provide access to quality, affordable personal health care services for all South Africans'. The document gives a long list of the services the NHI is likely to provide, which range from cardiology, dermatology, and neurology to oncology and cancer treatments, psychiatry, obstetrics, gynaecology, paediatrics, orthopaedics, and surgery (including organ transplants of various kinds). At the primary health care (PHC) level, the services to be provided will include 'sexual and reproductive' health care, along with optometry, 'oral health rehabilitation', and a comprehensive range of remedies for mental disorders and disability needs. Treatment for 'rare diseases' and 'dread diseases' will also be provided, along with comprehensive radiology services, including 'nuclear medicine and radiation oncology'.[2]

The White Paper clearly intends to make NHI coverage as comprehensive as possible. It claims that the services to be provided 'will not be based on a negative or positive list', but will instead be chosen on the basis of 'explicit guarantees', following Chile's example. But this is misleading, for Chile's system of Universal Access with Explicit Guaranteed Entitlements (AUGE in Spanish) in fact focuses on a list of 80 'priority' issues.[3]

What benefits the NHI will provide will ultimately depend on what the NHI Benefits Advisory Committee in time decides. The committee will also amend these benefits from time to time to reflect changes in 'the burden of disease', the demographic profile of the population, and the 'cost effectiveness and efficacy' of different treatment options. A large bureaucracy will be needed to make these 'changes and adjustments to the service benefits' and set out their likely impact on the NHI budget.[4]

NHI costs

The White Paper again fudges the key question of what the NHI is likely to cost. It remains adamant that NHI services must be free at the point of service, saying costs will be fully covered by the NHI Fund without any contribution from patients.[5]

Like the December 2015 draft, the White Paper says 'it is not useful to focus on getting the exact number indicating the estimated costs', as this is likely to require 'an endless cycle of revisions and attempts to dream up new revenue sources', as other countries have found. 'Focusing on the question of "what will NHI cost" is the wrong approach', the document adds, as this will very much depend on 'the services covered... and the resources needed'.[6]

Instead of trying to provide any realistic estimate of NHI costs, the White Paper simply repeats the figures provided in the December 2015 draft. It thus puts 'projected NHI expenditure' in 2025/26 (when the new system is supposed to be fully operative) at R256m in 2010 prices. This, it says, will 'take the level of public health spending from around 4% of GDP currently to 6.2% of GDP by 2025/26, assuming that the economy grows at an annual rate of 3.5%'.[7]

However, the last time South Africa experienced real GDP growth at anything like 3.5% was in 2011, when the growth rate reached 3.3% of GDP. Since then, the annual growth rate has steadily declined, reaching a fresh low of 0.3% in 2016. The 2017 growth rate is unlikely to exceed 0.5%, while growth rates in the foreseeable future will continue to be depressed by rising public debt, looming credit downgrades, failing business and consumer confidence, and escalating threats to property rights.[8]

> *If both public and private spending on health care in the current financial year is taken as the starting point and the health inflation rate is estimated at a somewhat more realistic 6% a year, then the NHI would cost R665bn in 2025.*

The White Paper is also misleading because it focuses solely on public healthcare spending, uses 2010 (rather than 2017) figures, and assumes that health spending will go up by only 4% a year, when this increase is below the average inflation rate over the past decade. If both public and private spending on health care in the current financial year is taken as the starting point and the health inflation rate is estimated at a somewhat more realistic 6% a year, then the NHI would cost R665bn in 2025.[9]

Important too is the question of how much NHI costs will rise after five, ten, and 15 years. Assuming that the health inflation rate remains at 6% a year, NHI costs would rise from R665bn in 2025 to R890bn in 2030 and R1 190bn in 2035. But health inflation has in fact been much higher in the last five years. In nominal terms, expenditure on public health care has gone up by roughly 45% over the past five years or by 9% a year on average. Spending on private health care has gone up by much the same proportion over this time.[10]

If health spending keeps increasing at 9% a year – and the NHI proposal offers no meaningful way of bringing it down, while further rand weakness could well drive it higher – then NHI costs are likely to rise

from R665bn in 2025 to R965bn in 2030, to R1 400bn in 2035, and then to R2 030bn in 2040. Assuming an average annual growth rate of 1% of GDP between now and 2019, followed by average annual growth of 1.5% from then until 2030, and average annual growth of 2% thereafter, the R2 030bn needed for the NHI in 2040 would amount to 30% of GDP in that year. Spending of this magnitude on health care within a scant 15 years of the system's introduction is completely unaffordable.

The financing of the NHI

Having wrongly assumed that NHI costs will be limited to R256bn in 2025, the White Paper further presumes that R72bn in additional revenue will be enough to fund this spending. But this projection is based on the unrealistic belief that the economy will grow by 3.5% of GDP a year between now and then.[11] If the annual growth rate is limited to 2% of GDP, then the funding shortfall will be R108bn in 2025, the White Paper says.

Focusing on the lower of these figures, the White Paper claims that the necessary R72bn could be raised by introducing both a 2% payroll tax and a 2% surcharge on taxable income. Alternatively, it could be generated through a 4% surcharge on taxable income, it says. But audit firm PriceWaterhouseCoopers (PWC) has modelled the likely yield from these tax increases and warns that they might raise only R50bn, rather than the R72bn required. In addition, notes PWC, if the growth rate is limited to 2% a year and the shortfall comes in at R108bn, then a 6% surcharge on personal income tax will be needed to generate this sum.[12]

However, if NHI spending in 2025 in fact amounts to R665bn, rather than R256bn, and the growth rate is limited to 2% a year, then the funding shortfall will not be R108bn but rather some R280bn. Very much bigger tax increases will then be needed to fill the gap at the start of the NHI, with ever larger levies required to fund its soaring costs thereafter. Yet the top rate of personal income tax has already been increased by 4 percentage points (from 41% to 45%, in the current tax year) for those with taxable incomes of R1.5m or more, so as to help generate the R43bn in additional revenue the government needs to fund its existing commitments over the next three years. In addition, growth in 2017/18 has been so limited that a R51bn shortfall in projected revenue collections already looms. At the same time, the government needs urgently to reduce its spending, if public debt – which has already quadrupled from some R630bn in 2008/09 to R2.5 trillion in 2017/18 and is expected to reach R3.4 trillion in 2021/22 – is to be contained.[13]

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The White Paper is entirely unrealistic in the tax increases it flags as sufficient to fund the NHI. The document does, however, recognise that even the limited tax increases it proposes could harm the economy and worsen unemployment. It acknowledges, for instance, that 'high marginal rates of personal income tax have distortionary economic impacts', as they reduce 'the disposable income of households', curtail 'consumption expenditure', and discourage 'economic activity'. It also admits that 'payroll taxes raise the cost of employment and may have adverse effects on job creation'.[14]

In addition, the White Paper at least implicitly recognises the reality of the Laffer Curve, stating: 'Increasing tax rates may generate higher revenue, but only up to a point, above which higher tax rates are counterproductive and revenue may decline.' (In the 1980s, US economist Arthur Laffer noted that tax hikes will in time reduce revenue, rather than increase it, because they erode the economic activity off which taxes are levied.) The document sees this decline as resulting mostly from 'tax avoidance (and evasion) responses', but in South Africa the small size of the tax base must also be factored in.[15]

Though some 18 million employees were registered for personal income tax in 2015, most had earnings below the tax payment threshold. Hence, 62% of all personal income tax that year was paid by some

560 000 people with annual taxable income of R500 000 or more. If increased taxes and reduced health services were to encourage 250 000 of these individuals to emigrate, the personal income tax that could be collected would be reduced by more than a quarter.[16]

The White Paper adds that some of the necessary funding for the NHI will be found by ending tax credits for medical scheme members, which currently cost the fiscus some R20bn a year, it says. In addition, the government will stop subsidising the medical scheme contributions payable by public servants and elected representatives, as these subsidies cost it some R27bn a year (see *Removing public sector subsidies*, below). But even if R47bn can be generated in these ways, this will still be far too little to meet the NHI funding need. The White Paper further suggests that much of the revenue currently allocated to provincial health departments will be redirected to the NHI. However, redistributing revenue in this way will not increase the amounts that can realistically be collected. Any such shift is also likely to be resisted by the provinces and might require a constitutional amendment.[17]

How the NHI is to be financed remains an intractable problem, which the White Paper makes little attempt to resolve. Instead, it simplistically claims that the NHI will significantly reduce health care costs by introducing 'a single-payer and single-purchaser fund', which will be responsible for 'the pooling' of all health care revenues and managing all health care expenditure.

The NHI Fund

According to the White Paper, 'the NHI Fund will... leverage its monopsony power to strategically purchase services that will benefit the entire population. Acting as a single payer, the NHI Fund will be able to yield the efficiency benefits of economies of scale'.[18]

> *Set fees and tariffs will be 'uniformly' determined and applied to providers in both the public and private sectors. This is likely to harm private practitioners and could prompt an exodus of health professionals.*

Costs will also be reduced through the introduction of price controls on all goods and services, it says. The government will thus decide:

- the uniform capitation fees (as opposed to fees for services) to be paid to general practitioners (GPs) and other primary healthcare providers in both the public and private sectors;[19]
- the 'capped case-based fees' to be paid to specialists (with some adjustment allowed for complexity);[20]
- the 'case-load payment systems' to be applied to hospitals, in place of current 'line-item budgeting';[21]
- the 'cost-based tariff schedule and volume contracts' to be used for diagnostic services, such as pathology and radiology;[22]
- the 'capped case-based fees' to be paid to providers of emergency medical services;[23] and
- the 'pricing and reimbursement mechanisms' to be applied to pharmaceuticals.[24]

In all instances, the set fees and tariffs will be 'uniformly' determined and applied to providers in both the public and private sectors. This is likely to harm private practitioners who have major overhead expenses from which their counterparts in the public service are spared. This could prompt an exodus of health professionals and, over time, the closure of many private hospitals.[25]

The White Paper stresses that the NHI Fund will be an 'active' and 'strategic' purchasing organisation, which will accurately assess the health needs of the population and then use 'the efficiency benefits of monopsony purchasing power and economies of scale' to meet these needs in the most cost-effective way. However, it is difficult to see how the NHI Fund's 'monopsony' buying power will make much difference when all prices will in any event be set by the state.[26]

Various other mechanisms will be also used to help reduce costs, the White Paper adds. Among other things:

- 'gate-keeping' by general practitioners will help 'curtail therapies that are not...cost-effective';[27]
- 'standard treatment guidelines' will be provided for primary healthcare services, as well as for adult and paediatric care at district and regional hospitals;[28]
- a 'strong referral mechanism' will be used to control people's access to services beyond the primary level;[29]
- a national system of 'health technology assessment' (HTA) will be used to 'ensure cost-effectiveness' and help 'prioritise' and 'select' interventions for diagnosis, treatment, and rehabilitation;[30] while
- diagnostic blood tests will generally be limited to those listed by the state as 'essential' and will be paid for on a 'cost-based tariff schedule' and, in time, a 'capitation-based reimbursement model'.[31]

The White Paper assumes that these comprehensive price and other controls will be effective in cutting costs, while enhancing quality and efficiency. However, the more likely outcome is that many valuable therapies, health technologies, and diagnostic tests will be ruled out as too costly.

In addition, once the government starts deciding the prices of goods and services, market mechanisms will no longer apply. Some prices are thus likely to be set too high (to help BEE businesses, for example), while others may be set too low to maintain supply. Moreover, without a market mechanism to help assess the extent of demand, bureaucrats will have to decide on what services, medicines, and other goods will be needed when and where. Inevitably, there will be over-provision in some areas and under-provision in others. This will generate huge inefficiencies in the system as a whole, which will add to costs rather than reducing them.

The White Paper assumes that these comprehensive price and other controls will be effective in cutting costs, while enhancing quality and efficiency. However, the more likely outcome is that many valuable therapies, health technologies, and diagnostic tests will be ruled out as too costly.

In addition, no amount of 'strategic' purchasing by a centralised fund will address the major drivers of health care costs. These are increasing utilisation rates resulting from an ageing population, high levels of chronic disease, and the rising costs of new medicines and technologies. Paul Harris, a former CEO of Rand Merchant Bank who is now a member of the High Level Panel of Parliament, writes with his associate Julia Price in a discussion paper on the NHI: 'There is no assurance that a single purchaser will be any more effective than several highly skilled purchasers in managing these complex trends. This is well demonstrated in many far richer countries, including Canada, the United Kingdom, and other European countries, where single purchaser and other NHI models are confronting exactly the same medical inflation pressures. The idea that a single purchaser will be able to force down prices and thus achieve lower costs is based on a lack of insight into current inflation dynamics.'[32]

The White Paper ignores these issues. It also brushes over the size of the bureaucracy that will be needed to administer the NHI Fund and various related structures, while discounting the inefficiency, wastefulness, and corruption that this massive new bureaucracy is sure to spawn.

The bureaucratic burden of the NHI

According to the White Paper, the NHI Fund will be buttressed by 12 'specific technical functional units'. These will include:[33]

- a 'Planning and Forecasting Unit',
- a 'Benefits Design Unit',

- a 'Price Determination Unit',
- an 'Accreditation Unit',
- a 'Purchasing and Contracting Unit',
- a 'Procurement Unit',
- an 'Information Technology Unit',
- a 'Provider Payment Unit',
- a 'Risk and Fraud Prevention Unit',
- a 'Legislative Unit', and
- an 'International Co-operation Unit'.

The document is largely silent as to what these sub-units are to do. It is also less forthcoming than its 2015 predecessor in describing the many additional committees that will be required. It is nevertheless clear that these various NHI sub-units are to be supplemented, at the national level, by:

- an NHI Board to oversee the NHI Fund;[34]
- various 'Clinical Peer Review Committees' to 'mitigate' the impact of inflexible treatment guidelines;[35]
- a National Health Information Repository and Data System to 'link...the NHI membership database with accredited and contracted healthcare providers' and report on the overall performance of the NHI system;[36]
- a Health Technology Assessment (HTA) entity to decide what technologies are sufficiently cost-effective to be made available;[37]

> *The White Paper is largely silent as to what these 12 sub-units of the NHI Fund are to do. It also brushes over how many additional structures will be needed. It is clear, however, that the NHI will require a host of further bureaucratic bodies at both national and district levels.*

- a National Health Commission, to prevent and manage diseases of lifestyle, including cardiovascular ailments and type 2 diabetes;[38]
- the (already existing) Office of Health Standards Compliance (OHSC), to assess whether health providers and facilities qualify for accreditation and hence for participation in the NHI;[39] and
- Functional Business Units at central hospitals to help manage costs and contract directly with the NHI Fund.[40]

These national structures will be supplemented by a range of further bodies at the district municipality level, some of which are already being established. Each of South Africa's 44 municipal districts will have:

- Municipal Ward-Based Primary Health Care Outreach Teams, to assess the health needs of all households within each municipal district;[41]
- an Integrated School Health Programme to monitor and meet the health needs of pupils;[42]
- District Clinical Specialist Teams to build capacity at the primary level and 'strengthen the use of clinical guidelines';[43]
- Contracting Units for Primary Health Care or CUPs, which will contract with primary health care providers and pharmaceutical services;[44]
- District Health Management Offices to manage public health programmes and co-ordinate the provision of necessary infrastructure and support services;[45]
- Clinic Committees in all primary health care facilities to 'provide advice', run public health campaigns, and 'play an advocacy role for the communities they represent';[46] and

- other district offices (it seems) to co-ordinate the provision of services through ward-based outreach teams, school health teams, fixed and mobile public sector facilities, and 'contracted private providers' so to achieve 'the PHC...vision of integrated and comprehensive services'.[47]

The White Paper, like its 2015 predecessor, makes no attempt to quantify the costs of this bureaucracy. Its estimate of the R256bn the NHI will cost in 2025 also overlooks these expenses. Yet all these new administrative entities will have to be suitably staffed, remunerated, equipped, and provided with appropriate office or other working space.[48]

How big will these entities be? This is difficult to judge, but some attempt can be made to quantify the likely needs of the Provider Payment Unit, which is one of the 12 sub-units to be established within the NHI Fund. The key task of this unit will be to make all the payments that will be due to hospitals, clinics, doctors, specialists, nurses and other practitioners for the services they have provided to patients free of charge.

The experience of the statutory Compensation Fund is illustrative here. The Compensation Fund receives the mandatory 'workmen's compensation fees' which most employers and their staff are obliged to pay to compensate employees who are injured at work. From these monies, the Compensation Fund pays the medical fees of the doctors and specialists who have treated injured employees. It also pays out compensation to the employees themselves. The fund receives roughly R11bn a year in income and administers some R56bn in assets.[49]

> *In 2015 when R2.6bn was paid out, the Compensation Fund had some 1 240 employees and managed to process roughly 75 000 claims a month. By contrast, Discovery Health has 4 000 employees, who process an average of 6 million claims in every month.*

Between 2013 and 2015, the Compensation Fund paid out R6.1bn on medical claims: R2.1bn in 2013, R1.4bn in 2014, and R2.6bn in 2015. According to Dr Johann Serfontein of the HealthMan consultancy, in 2015 (when R2.6bn was paid out) the Compensation Fund had some 1 240 employees working on these claims and managed to process some 900 000 of them, or roughly 75 000 claims a month. By contrast, Discovery Health, the largest private medical scheme in the country, has 4 000 employees who process an average of 6 million claims in every month[50] and are far more efficient. In addition, providers generally have to wait significant periods before they are reimbursed by the Compensation Fund, while many of them have claims which have remained unpaid for many years (as further described below).[51]

Asks Dr Serfontein: 'If an R11bn fund responsible for paying medical claims cannot be effectively administered, how will the NHI Fund be managed?' The NHI budget is estimated by the White Paper at R256bn a year, which is about 23 times larger than the Compensation Fund's annual income of R11bn. The number of claims payable is likely to be 100 times more. If the payment levels achieved by the Compensation Fund in 2016 are used as a barometer, this suggests that the Provider Payment Unit will need to employ some 125 000 people to handle the claims it receives each year.[52] Providing salaries, pensions and other benefits to all these new employees will not come cheap.

The Procurement Unit, another sub-unit of the NHI Fund, is presumably to be given the task of paying for all the medicines, consumables, medical devices, medical equipment, diagnostic tests, and other goods and services that will be needed in meeting the health requirements of some 56.6 million South Africans.[53] Given the volumes in issue, this unit may require a further 125 000 officials to handle these purchases. Yet the Provider Payment and Procurement Units are only a small part of the overall bureaucracy that will be needed to administer the NHI.

Proponents of the NHI are silent about the size of the bureaucracy required, how much it will cost, and how inefficient it might be. Instead, they simplistically claim that the NHI will help to bring down costs and be much cheaper than the current system, the costs of which they constantly castigate. However, as world-

renowned public intellectual Professor Thomas Sowell of Stanford University has observed: 'It is amazing that people who think we cannot afford doctors, hospitals, and medication somehow think that we can afford doctors, hospitals, and medication – and a government bureaucracy.'[54]

Fraud and corruption

Unlike the current White Paper, its 2015 predecessor was reasonably forthcoming about the risks of increased fraud and corruption under the NHI. It warned, in particular, that both patients and providers might try to cheat the system, while briefly acknowledging that NHI bureaucrats and hospital staff might not be blameless either. The current White Paper brushes over such problems, and makes no attempt to explain how the Risk and Fraud Prevention Unit (to be established as a sub-unit of the NHI Fund) is to counter them.[55]

The lodging of fraudulent claims against medical schemes is already a major problem costing the industry some R22bn a year. According to the Healthcare Forensic Management Unit of the Board of Healthcare Funders, 'at least 7% of all medical claims in South Africa are fraudulent and the figure could be as high as 15%'. In July 2017 a spokesman for Medscheme's forensic unit thus warned that South Africa 'stands to lose billions of rands, due to the plundering of NHI funds' unless effective steps are taken to prevent this.[56]

In addition, fraud and inflated pricing in public procurement are already rife. As Kenneth Brown, chief procurement officer at the National Treasury, warned in October 2016, some 40% of the government's R600bn budget for goods and services – amounting to roughly R240bn a year – is currently tainted by 'inflated prices and fraud'.[57] Unless this trend can be reversed, the hundreds of billions of rand in the procurement budget of the NHI Fund are likely to be similarly compromised.

> *If current safeguards continue to be chipped away, the scourge of corruption is sure to increase. Hence, once hundreds of billions of rands are added to the state's procurement spending via the NHI system, it will be difficult to prevent the large-scale looting of these monies.*

In the past year, moreover, the Treasury's controls against corruption seem to have been weakened. Mr Brown resigned from his post in December 2016, while his successor, Schalk Human, who had been appointed on an acting basis, was shifted back to his previous job in September 2017. He was replaced by Willie Mathebula, a Treasury official of some 15 years' standing. But DA finance spokesman David Maynier described the shift as 'shocking', saying Mr Human had been widely seen as 'one of the key soldiers' in the battle against corruption and profligate spending at state-owned enterprises (SOEs). Mr Mathebula may also be planning to curtail the powers of his office and make it easier for state entities to sidestep the Treasury's procurement rules.[58]

In the last few months, more than 100 000 leaked Gupta e-mails have also cast new light on how many state tenders have been brazenly manipulated to enrich the Gupta family and those – ranging from the president's son Duduzane Zuma to key ministers – it has reportedly suborned. Former finance minister Pravin Gordhan, who was trying to tighten up the safeguards against procurement fraud, was ejected from his cabinet post in a midnight reshuffle on 31st March 2017. His successor, Malusi Gigaba, who himself seems to have helped the Guptas to 'capture' the boards of key SOEs, has seemingly done little to end procurement abuses or ensure that fraudulent tenders are set aside. At the same time, the country's principal anti-corruption agency, the Hawks, is being inordinately slow in investigating or acting against the abuses revealed in the Gupta e-mails and elsewhere.[59]

If current – and already ineffective – safeguards continue to be chipped away, the scourge of corruption is sure to increase. Hence, once hundreds of billions of rands are added to the state's procurement spending via the NHI system, it is doubtful whether its Risk and Fraud Prevention Unit will be able to prevent the large-scale looting of these monies.

Major inefficiency within the NHI Fund

Even if fraud and corruption can be countered effectively, the problem of inefficiency is likely to remain. The example of the Compensation Fund is again relevant here, for the fund is notoriously inefficient and has often failed to pay out on doctors' claims in time.

In July 2009 a company called Compensation Solutions (Pty) Ltd or Compsol, which handles between 40% and 60% of all medical claims against the Fund, obtained a High Court order instructing the Fund to pay or process a number of outstanding claims. But by September 2013 some R127m still remained unpaid, prompting Compsol to turn to the courts once again. The High Court ordered payment to be made within ten days, but again this was not done.[60]

Compsol applied to have the Compensation Commissioner, Shadrack Mkhonto, committed to prison for contempt of court for his repeated failures to uphold the 2009 judgment. In April 2016 the Supreme Court of Appeal (SCA) found Mr Mkhonto guilty of contempt and sentenced him to three months' imprisonment, suspended for five years. In a searing judgment, the acting president of the SCA, Justice Mandisa Maya, said the Fund's behaviour had been 'scandalous' and 'deserved the strictest censure'. She also condemned the 'utter disdain' Mr Mkhonto had shown 'for court procedures and orders'. But in September 2017 the SCA judgment was set aside on appeal to the Constitutional Court, which found that Mr Mkhonto's conduct had been neither wilful nor in bad faith.[61] This Constitutional Court ruling will doubtless make it harder in the future to compel officials to pay up on time.

> *A Sama survey, conducted among medical practitioners in Gauteng, found that 65% of them had been adversely affected by the Compensation Fund's failure to pay their claims. The average amount outstanding was now R895 000 per doctor, said Sama.*

The problem of non-payment by the Fund persists. In June 2015 Compsol said it had obtained more than ten judgments against the Fund, but total unpaid debt owing to its members had nevertheless risen to some R555m. It also suspended its prefunding services for doctors, saying it was already carrying 'vast amounts' of prefunded accounts and did not know when it would be paid. Compsol MD Fritz Luttich added that the Fund's Umehluko computer system, which was supposed to speed up the settlement of claims, had 'virtually ground to a halt due to its dysfunctionality and incapacity to process and pay the volume of claims' in issue.[62]

The South African Medical Association (Sama) added that, with Compsol's prepayment system no longer available, many doctors were refusing to attend 'injured-on-duty' cases because they had no confidence they would be repaid by the Fund. A Sama survey, conducted among medical practitioners in Gauteng, found that 65% of them had been adversely affected by the Fund's failure to pay their claims. The average amount outstanding was now R895 000 per doctor, said Sama. The DA commented that 'these figures were astronomical and could easily result in small medical practices having to shut their doors'.[63]

The situation remained unresolved in April 2016, when the Radiological Society of South Africa (RSSA) and 19 individual radiological practices sued the Fund over its failure to process and pay out claims amounting to some R121.5m. The then commissioner, Vuyo Mafata, conceded that the Fund had a history of unpaid claims, but stated that its Umehluko system had helped it improve its turnaround time to an average of just 60 days. But Dr Richard Tuft, executive director of RSSA, disagreed, saying the fund's capacity to process claims had in fact worsened under Umehluko. According to Dr Tuft, doctors were waiting an average of 350 days to be reimbursed by the Fund, whereas medical schemes repaid them within 12 to 20 days in general. Repeated efforts to negotiate a solution had also failed, 'leaving litigation as the last resort'.[64]

The overall scale of the problem is even bigger than these figures suggest. In April 2015 the director general of labour, Thobile Lamati, acknowledged in Parliament that the Fund had an overall backlog of

231 000 outstanding claims, cumulatively amounting to some R23bn. Some of these claims dated back ten years. Mr Lamati pledged that the backlog would be cleared within two months, but progress has again been slow. In 2015, as earlier noted, R2.6bn in medical claims was paid out, leaving the bulk of unpaid claims still unresolved.[65]

In April 2017 Mr Lamati told a media briefing that the Fund's backlog had been reduced to some 60 000 claims, most of them 'old cases which had not been processed because of incomplete documentation'.[66] Major questions as to the accuracy of this assessment nevertheless remain.

The Fund is not alone in its inability to pay out claims in time. Similar problems are evident at the Compensation Commission for Occupational Diseases, which is supposed to provide compensation for mineworkers suffering from lung diseases contracted on the job. In July 2017 the Commission had an estimated backlog of some 700 000 unpaid claims, many of them relating to former mineworkers who were now difficult to trace. This overall figure included some 94 000 claims (down from 106 000 in November 2016), which had already been approved by the Medical Bureau for Occupational Diseases but had yet to be paid out.

The Commission's financial records have long been chaotic, with major backlogs in the recording of revenue received and claims submitted. (Its financial statements for 2010/11 and 2011/12, for example, were submitted to Parliament only in August 2017.) By June 2017 the Commission had increased its payout rate to 1 500 a month – but the backlog in approved claims remained large, while the claims of between 300 000 and 500 000 mineworkers still needed to be assessed. Wrote journalist Tamar Kahn in *Business Day*: 'The fact that the department is still struggling to get the [commission] to provide workers with an efficient compensation fund has broader implications, as it raises questions about [the Department's] capacity to oversee the ambitious NHI Fund.'[67]

The RAF also has a backlog of some 5 600 claims, cumulatively worth some R8.4bn. Court-ordered deadlines for payment are so often ignored that 'more than 1 000 warrants of execution are received from sheriffs every month... and it is common for RAF assets to be attached, removed, and sold,' as the organisation acknowledged in February 2017.

A similar story is evident at the Road Accident Fund (RAF), which is funded by the fuel levy and is supposed to pay the claims of people injured in road accidents. The RAF receives a monthly income of about R3bn and its roughly 2 000 employees make some 30 000 payments monthly. However, this is again a tiny fraction of the 6 million claims that Discovery's 4 000 employees pay out every month. The RAF also has a backlog of some 5 600 claims, cumulatively worth some R8.4bn. Among those waiting to be paid are people whose compensation claims have already been settled or decided by the courts. Yet court-ordered deadlines for payment are so often ignored that 'more than 1 000 warrants of execution are received from sheriffs every month... and it is common for RAF assets to be attached, removed, and sold,' as the organisation's media unit acknowledged in February 2017.[68]

The gross inefficiencies at the Fund, the Commission, and the RAF have generally remained unresolved over many years. They provide some indication of the problems likely to arise under the NHI. Those problems are likely to loom very much larger, of course, for the NHI Fund will have a budget of at least R256bn a year, compared to R11bn for the Fund and R36bn for the RAF. Moreover, instead of having to deal with only small groups of South Africans, the NHI Fund will be responsible for paying for all the health services provided by all accredited hospitals, clinics, doctors, specialists, nurses, and other health providers to some 56.6 million South Africans. It will also have to pay for all the medicines, medical devices, diagnostic tests, consumables, and other relevant goods and services that may be supplied to the population in any given year. The three funds earlier described have failed to deal effectively with a far smaller number of claims.

Imagine, then, the inefficiency and inordinate delays that are likely to arise once the NHI Fund has to start paying out on hundreds of millions of claims each year.

Some concrete numbers may help to illustrate the point. Once the NHI has been introduced, every South African might take advantage of its 'free' services to consult a GP twice in a given year, and might each time be provided with a single medicine. The NHI system would then have to pay out four times for each person, giving it a total of 226 million payments to process in that year. In practice, given South Africa's heavy burden of disease and high level of trauma cases, the number of payments needing to be made each year will be very much greater.

The inevitable result will be long delays in paying doctors and other health practitioners. As Dr Serfontein has noted, if the NHI Fund manages to pays as efficiently as the Compensation Fund now does – which seems far too optimistic – doctors will commonly wait 70 days to be paid for services they have already provided free of charge to patients. Often they will wait for 350 days (close on a year) and sometimes they will wait for a decade. Often, they will have to resort to litigation to recover the amounts long due to them. At times, even when their applications succeed and the courts order the NHI Fund to reimburse them, they will have to wait for the sheriffs of the court to seize sufficient NHI Fund assets to pay them their due. Yet even a 70-day delay in payment could make it very difficult for doctors in private practice, in particular, to cover their overhead costs and maintain their operations.[69] The government seems to assume that all health providers will be willing to wait long periods to be paid – but their preference might be to emigrate instead.

Certification and accreditation for NHI participation

All health providers and facilities, whether public or private, that wish to participate in the NHI will first have to be assessed and certified by the Office of Health Standards Compliance (OHSC). Once OHSC certification has been obtained, the Accreditation Unit of the NHI Fund will decide whether accreditation should follow.

> *At present, most public clinics and hospitals would not be able to take part in the NHI as their compliance levels with core standards are too low. In 2014/15, for example, the OHSC inspected 417 out of roughly 3 900 state facilities and found that only 3% of them were 'compliant', while 13% were 'conditionally compliant'.*

The OHSC was established in 2013 to help monitor the compliance of public hospitals and clinics with 'seven domains and six national core standards'. The seven domains include patient safety and clinical care, along with facilities, infrastructure, corporate governance, and operational management. The six national core standards cover cleanliness, staff attitudes to patients, infection control, security, waiting times, and the availability of medicines. Under the NHI proposal, health facilities that meet these standards will be certified by the OHSC and will then be considered eligible for participation in the new system.[70]

How many health providers or facilities will qualify for certification by the OHSC remains uncertain. At present, however, most public clinics and hospitals would not be able to take part in the NHI as their compliance levels are too low. In 2014/15, for example, the OHSC inspected 417 out of roughly 3900 state facilities and found that only 3% of them were 'compliant'. Another 13% were compliant 'with requirements' or were 'conditionally compliant'. The remaining 84% were non-compliant, of which 16% were 'conditionally compliant with serious concerns', 28% were 'non-compliant' and 40% were 'critically non-compliant'.[71]

Since then, compliance standards seem to have deteriorated. Data prised out of the OHSC late in 2016 (by *Business Day* journalist Tamar Kahn under the Promotion of Access to Information Act of 2000) shows that a total of 1 427 public facilities have been inspected by the OHSC over the past four years. Of these, only 89 (6% of the total) scored 70% or more, the level identified by the OHSC as a 'pass'. Most facilities continued to fall short on such essentials as infection control and the availability of medicines.[72]

A comparison of provincial compliance at the primary health care (PHC) level also shows a general decrease in performance from 2012 to 2016. (The 2012 figures come from a 'baseline' audit carried out before the OHSC was established, while the 2016 figures were gathered by the OHSC itself.) Compliance among the clinics and community health centres reviewed edged up by a single percentage point in two provinces: in Mpumalanga (where it rose from 47% to 48%) and in the Northern Cape (where it went up from 40% to 41%). But compliance diminished in all other provinces, including Gauteng and the Western Cape. Moreover, whereas in 2012 four provinces had compliance scores above 50%, in 2016 only Gauteng came in above the 50% level with a score of 55% (down from 69% in 2012). Some provinces did particularly badly, for only two of Limpopo's 59 clinics and five of the 53 clinics reviewed in the Free State scored over 50%.[73]

Commenting on compliance levels at these PHC facilities and various provincial and other hospitals, OHSC chairman Professor Lizo Mazwai expressed concern at 'some evidence of significant deterioration in the quality of health care' at the health establishments inspected. He also warned of 'vacant clinical and allied professional posts, inadequate infrastructure and maintenance..., [and shortages of] medical equipment, medical supplies, and consumables, including pharmaceuticals'.[74] Though he blamed these problems primarily on 'budget constraints', limited revenue is only a small part of the problem. The much bigger challenge is that the major tax revenues allocated to public health care are often badly managed and poorly used.

> *If private healthcare practices number 31 000, the OHSC will have to certify a total of some 34 900 facilities and practices every four years, or roughly 8 725 a year. But if private health care practices indeed number 74 000, then it will have certify some 77 900 every four years, or roughly 19 475 a year.*

The White Paper ignores the key issue of whether a mere 16% (or 6% on the most recent figures) of public health facilities will qualify to take part in the NHI. It also brushes over the magnitude of the certification task that will confront the OHSC. South Africa has close on 3 900 public health facilities and some 200 private hospitals, all of which will have to be certified by the OHSC if they are to take part in the NHI. The country also has between 31 000 and 74 000 private healthcare practices (the data is contradictory), many of which will need certification too. In addition, an OHSC certificate remains valid for only four years, after which renewed inspection and assessment is required. Yet the OHSC has only 35 inspectors – and will clearly need many more if it is to cope with the volume of work required.[75]

If the lower number of private healthcare practices (31 000) is correct, the OHSC will have to certify a total of some 34 900 facilities and practices every four years, or roughly 8 725 a year. But if the number of private health care practices is indeed 74 000, then it will have certify some 77 900 every four years, or roughly 19 475 a year. Many more inspectors will need to be appointed to manage the workload, on either the lower or higher scenarios. But such individuals will be difficult to find when the skills shortage across the country is so acute. Their salary costs will also be significant. This suggests, as Dr Serfontein points out, that the annual OHSC budget would have to increase to R700m on the lower scenario, and to R1.4bn on the higher one.[76] Again, however, the White Paper overlooks these additional funding requirements.

The number of health providers potentially needing OHSC certification is even higher. Registered health care professionals include some 42 300 GPs and specialists, along with roughly 6 000 dentists, 4 600 occupational therapists, 6 900 physiotherapists, and 7 800 radiographers and approximately 280 000 nurses of various kinds.[77] Not all these registered practitioners may want or need to be assessed, but the number of providers in issue (especially as regards nurses) indicates that the OHSC's certification task is likely to be enormous.

This holds major ramifications for the NHI system. Unless the OHSC is able to certify all private facilities and providers, these health resources will not become available to the NHI. Unless this problem can be

resolved – and unless poor compliance standards in the public sector can also be overcome – there is a real risk that the NHI system will leave 56.6 million South Africans dependent on the 16% (or 6%) of public facilities that currently merit OHSC certification.[78] On this basis, waiting times for even the simplest medical treatments are likely to become inordinately long.

Certification by the OHSC is also only the beginning of a longer process, for accreditation to take part in the NHI must thereafter be granted by the Accreditation Unit within the NHI Fund. In deciding whether to accredit health facilities or providers already certified by the OHSC, this sub-unit must take into account the 'health needs' of the 'catchment' population, as indicated by its 'demographic (age/sex) composition and epidemiological profile'. The extent of 'provider compliance with specific information and performance criteria' will also have to be assessed. Relevant factors will include 'indicators of clinical care, health outcomes, and clinical governance', the White Paper says.[79] These criteria are so vague that the decision-making process is likely to be prolonged and sometimes arbitrary.

The role of medical schemes

South Africa has a world-class system of private health care, to which some 30% of its population on average, or roughly 17 million people, have access through their medical schemes, health insurance policies, or out-of-pocket payments. In the 2017/18 financial year, spending on private health care is expected to amount to R213bn, of which 83% (R177bn) will go to medical schemes, while R29bn will be spent on out-of-pocket expenses, and R5bn will go to medical insurance. South Africa's 82 medical schemes are thus vital in providing access to private health care.[80]

> *The number of people belonging to medical schemes has risen from 6.9 million in 1997 to 8.9m in 2016. The demographic representation of medical schemes members has changed substantially, for 49% of members are now black Africans, while 10% are coloured, 7% are Indian and the remaining 34% are white.*

The number of people belonging to medical schemes has risen from 6.9 million in 1997 to 8.9m in 2016. However, because the South African population has also increased over this period, medical scheme membership as a proportion of the total population has remained much the same, at around 16%. The demographic representation of medical schemes members has nevertheless changed substantially over the years, for 49% of members are now black Africans, while 10% are coloured, 7% are Indian and the remaining 34% are white.[81]

The membership profile of medical schemes is already very different from what it was in the apartheid era. Many more black South Africans would also be able to benefit from medical schemes and private health care if the ANC government were to focus on increasing skills and promoting investment, growth, and job creation. Instead, the ruling party remains hostile to both private health care and the medical schemes which help to fund it. The government has thus already introduced various regulations (as outlined below), which have pushed up the costs of medical scheme membership and made this increasingly difficult for people to afford. It now plans to use the NHI to put an end to almost all medical schemes and bring private health care under comprehensive state control.

According to the White Paper, the NHI will be funded through 'mandatory prepayment' into the NHI Fund. 'Individuals will not be allowed to opt out of making the mandatory prepayment towards NHI, though they may choose not to utilise NHI healthcare services.'[82] This in itself will be enough to bring about the demise of most medical schemes, for many medical scheme members will battle to afford both their medical aid contributions and the additional taxes required to fund the NHI.

More seriously still, the White Paper (like its 2015 predecessor) still seeks to confine medical schemes to covering only those services that are not available under the NHI. According to the document, 'once NHI

is fully implemented, medical schemes will offer complementary cover to fill gaps in the service coverage offered by the NHI'. The current White Paper declines to spell out what the consequence of this restriction are likely to be. The 2015 document was less coy, however, stating that 'the number of medical schemes will reduce from the current 83 to a much smaller number'.[83]

Restricting medical schemes to providing complementary cover is likely to sound their death knell. A medical scheme would still be able to cover a rare disease – perhaps haemophilia, or uncontrolled bleeding – if this was not included in the NHI package. But the pool of potential members wanting cover of this kind would be very small. Premiums would thus have to be set so high that only the very rich would be able to afford them.[84]

Few, if any, medical schemes will be able to survive in these circumstances. The main source of funding for private health care will thus mostly come to an end. Some private practices might still be able to continue on a cash basis, but most would struggle to survive – especially as many of their potential patients would also be paying high payroll and income taxes to help fund the NHI.[85] In addition, practices will no longer be private in any real sense of the term, once the state is given the power to decide on all provider fees, all other prices, and all aspects of health treatment.

Ramifications of the White Paper

The NHI proposals in the current White Paper are essentially the same as those in the 2015 draft and in the 2011 Green Paper before then. Hundreds of public submissions highlighting the many problems in the proposed NHI system (160 on the December 2015 draft alone)[86] have thus been ignored. The only real change is that the current document omits much of the detail earlier provided. The minister's thinking has thus remained unchanged, but the Department of Health has seemingly become more wary of spelling out its plans.

> *Few, if any, medical schemes will remain once the NHI begins. The main source of funding for private health care will thus mostly come to an end. Some private practices might still be able to continue on a cash basis, but most would struggle to survive.*

All the key disturbing features of the NHI remain in place. The NHI Fund is still to have control, not only over all health care monies, but also over every aspect of health care in the country: from the treatment protocols to be applied to the medicines to be prescribed, the diagnostic tests to be allowed, and the health care technologies to be permitted. The bureaucratic burden will be enormous, while the decisions made by officials will often be self-serving, corrupt, or otherwise flawed. The NHI Fund will also control all prices, including the uniform fees to be paid to healthcare providers in both the public and private sectors. The removal of the market mechanism in health care will make for enormous inefficiencies, while the scope for corruption will be huge.

The NHI Fund will be administered solely by the state, without private sector help. The vast task it will confront in handling at least 226 million claims each year (and no doubt many more), will make it far less efficient than the already struggling Compensation Fund, Compensation Commission for Occupational Diseases, and Road Accident Fund. Doctors and other health practitioners are thus likely to wait months, if not years, to be reimbursed for services they have already provided to patients free of charge. Payments to the suppliers of medicines and other consumables are likely to be equally tardy, which is sure to reduce or terminate the supply of these essentials. Maintenance of clinics, hospitals, and essential equipment will falter even further.

The White Paper, like its 2015 predecessor, barely acknowledges the many problems in the public healthcare system. It also lacks any realistic proposals to overcome the shortage of healthcare providers,

improve the management of healthcare facilities, ensure a more effective use of tax revenues, increase dismal compliance levels with OHSC norms and standards, or put an end to the medical negligence that has caused so many unnecessary deaths and so greatly marred the lives of thousands of South Africans.

In 2011, when the green paper on the NHI came out, the *Financial Mail* warned that the NHI was likely to become 'another costly white elephant' which would also cause great damage to the healthcare system. It added:[87]

'We do not need a new health system. We already have an extensive state-funded network of clinics and hospitals, supported by medical schools that are generally world-class. The public system is, in principle, available to everybody, but it has a reputation for being so badly managed and poorly resourced that anyone who can afford to pay medical aid fees chooses to buy the private services that are available. It is the unemployed and the poor who have no choice but to use public facilities.

'The service they get is not universally bad. There are pockets of excellence, such as the burns unit at Bara. Nor does the dysfunction in the system have much to do with the quality of its health professionals (though there aren't enough of them). Simple managerial incompetence has brought many hospitals to their knees and driven away nurses and doctors. Lifts don't work, operating theatres are hit by power failures, nurses are sexually assaulted, food and linen are routinely stolen, service providers go unpaid, and patients have to bribe employees to get food. Even simple challenges like queue management at pharmacies seem beyond administrators, many of whom are neither equipped nor qualified for the work they are supposed to do.

The most pressing of all problems – how to fix the public healthcare system and ensure that it starts to provide value for money – remains entirely unresolved. Instead, the NHI's main focus is on putting an end to South Africa's outstanding system of private health care.

'Instead of attending to these mundane basics, the government wants to add yet more layers of expensive – and inevitably inefficient – bureaucracy. The NHI sounds grand and visionary, but it is the health equivalent of the disastrous outcomes-based education system that ruined the future of tens of thousands of children before it was abandoned. Simply throwing more money at the health system through the NHI… will merely create more positions for more lazy, inefficient, unaccountable bureaucrats, with added opportunities for corruption through the imposition of even more complex and centralised procurement processes.

'The NHI is misguided. Like many of government's grand schemes that have sought to divert attention from basic intractable realities, it has not been properly thought through. South Africa cannot afford it and it will end in tears – after doing a lot of damage along the way.'

None of these salient criticisms has been addressed in the White Paper. The most pressing of all problems – how to fix the public healthcare system and ensure that it starts to provide value for money – remains entirely unresolved. Instead, the NHI's main focus is on putting an end to South Africa's outstanding system of private health care. The White Paper does not, of course, acknowledge this NHI objective. But the effective nationalisation of private health care will inevitably be the result once the government takes control of pricing, payment, treatment protocols, and virtually every other aspect of health care.

Though nationalisation is the real aim, private hospitals will not overtly be seized by the government. Nor will they be directly expropriated and taken into the ownership of the state, as that would require the payment of compensation under the property clause (Section 25) in the Constitution. Instead, an 'indirect' or 'regulatory' form of expropriation will be used.

Under the NHI, the fees due to hospitals for the health services they provide free of charge to patients will be decided by the bureaucrats employed by the NHI Fund. NHI officials will also decide on the fees to

be paid to specialists, the medicines to be prescribed, and the prices to be charged for these. What medical devices, medical technologies, consumables, and other goods and services may be used to treat the sick will also be decided by NHI officials, while price controls will again apply.

Private hospital groups will still own their hospitals, but they will lose most of the usual powers and benefits of ownership – including the capacity to run their operations at a profit – under the comprehensive controls to be imposed by the state. These controls will give rise to a regulatory or indirect expropriation. However, no compensation will be payable to private hospitals for their resulting losses because the Expropriation Bill of 2015 (now back before Parliament for re-adoption), defines expropriation as the compulsory 'acquisition' of property by the state – and this definition will not be satisfied. (The Bill's definition contradicts the accepted meaning of expropriation and is prima facie unconstitutional, but whether the Constitutional Court will strike it down remains uncertain.)[88]

All private medical practices will face essentially the same situation as the private hospitals. The state will not 'acquire' them, but the private GPs and other health professionals who own them will generally lose their capacity to run them at a profit. They will also lose much of their professional capacity to treat patients as they think best, to which many may object.

Most private medical schemes will also confront the regulatory expropriation of their operations. Their situation will be even worse, however, for they will be confined to covering 'complementary' health services (cosmetic surgery, for example) not included in the NHI package of benefits. Few medical schemes are expected to survive. The collapse of most will, of course, put great pressure on any remaining private medical practices to join the NHI and subject themselves to its controls.

Private hospital groups will still own their hospitals, but they will lose most of the usual powers and benefits of ownership – including the capacity to run their operations at a profit – under the comprehensive controls to be imposed by the state. All private medical practices will face essentially the same situation.

If these measures are not enough to bring about the demise of most private practices, the NHI Fund will always be able to encourage this outcome by delaying payment of the fees due to hospitals, specialists, GPs, and others for the health services they have already provided free of charge. If experience with the statutory Compensation Fund is taken as a guide, delays of 350 days could be the norm. Payment delays of ten years or more could also be encountered.

Few private hospitals or private practices are likely to survive these heavy blows. Many specialists and other practitioners could also decide to emigrate. So too could much of the middle class, whose skills and buying power are vital to the economy. Tax revenues will then decrease, making it much harder to fund health services – or to sustain state spending on a host of other key needs.[89]

The overall supply of health services is thus likely to diminish, just as the demand for them increases exponentially under the promise of free care for all. Long waiting times will inevitably result, while the quality of the treatment that can still be provided is sure to deteriorate, rather than improve.

Most South Africans seem unaware that the NHI will put an end to private health care. Many may also find it difficult to believe that the ruling party could wish to terminate that part of the health system which works the best. But Dr Kgosi Letlape, then president of the South African Medical Association, warned of this intention as far back as 2004, when he stated that the government's underlying agenda was to 'get rid of the private sector' in health care.[90]

In a discussion paper prepared for the High Level Panel of Parliament, Mr Harris and Ms Price highlight the overall adverse consequences the NHI proposal is likely to unleash. They write:[91]

'The NHI model is fundamentally flawed and is likely to result in a worse health care environment for all

South Africans, with a particular burden on the poorest citizens... It is a R250bn (at least) experiment that creates the risk of extreme destabilisation. It will not achieve the results its proponents suggest, but will in fact put the most vulnerable members of society at risk. The result of this model could be catastrophic for the country's health care system, and for the economy and society as a whole.'

Despite all the enormous difficulties the NHI is likely to unleash, the government is now pressing ahead with implementation. New committees are being appointed to oversee the process, while the NHI Fund is soon to be established. In addition, affordable access to private health care is being further reduced to help buttress the government's flawed claim that the NHI offers the only way to meet the country's needs.

Pushing ahead with implementation

New committees being established

On 7th July 2017, a scant week after the gazetting of the White Paper, the Department of Health gazetted details of the 'institutions, bodies and commissions' that are to be established to help implement the NHI. Towards the end of the following month, on 25th August, it called for nominations for the people needed to serve on these various committees. However, it allowed only a week for the nominations process, which expired on 31st August 2017.[92]

> *All these new institutions are to be established under Section 91(1) of the National Health Act of 2003, which empowers the minister to establish such 'advisory and technical committees as may be necessary to achieve the objects' of the statute. However, these objects make no mention of the NHI.*

All these new institutions are to be established under Section 91(1) of the National Health Act of 2003, which empowers the minister to establish such 'advisory and technical committees as may be necessary to achieve the objects' of the statute. However, these objects make no mention of the NHI. The establishment of the proposed bodies is thus *ultra vires* the Act (beyond the powers conferred by the statute) and prima facie unlawful.[93]

The seven proposed bodies (listed in the order in which they appear in the *Gazette*) are briefly as follows:

National Tertiary Health Services Committee

This committee is mandated to prepare 'a national tertiary services plan', which must make provision, among other things, for:[94]

- a 'referral system' from lower healthcare levels,
- 'a comprehensive set of clinical guidelines',
- 'rationing criteria' for tertiary care,
- the provision of 'appropriate medical equipment' and 'staffing levels', and
- the 'equitable allocation of budgeted funds' within an overall 'costing and funding model'.

National Governing Body on Training and Development

This committee is to develop 'a clear vision' and policy recommendations for education and training in health sciences. It must develop norms and standards to be used in student training, recommend ways in which medical training can realistically be expanded, and develop a costing and funding model that ensures an equitable allocation of funds. It must also consult with professional groups, private specialists and medical faculties regarding 'the skills mix and clinical competencies required...in a NHI system'.[95]

National Health Pricing Advisory Committee

The primary objectives of this committee are to develop:[96]

- 'a risk-adjusted capitation system, with an element of performance-based payment', which will be 'used to pay contracted providers at the PHC [primary health care] level';

- a 'case-mix system for the reimbursement of hospitals and medical specialists', with payments based largely on the concept of 'diagnosis-related groups or DRGs'.[a] These tariffs are to 'apply to all hospitals', whether public or private, and will have 'two separate components: a reimbursement of hospital costs and an honorarium for medical specialists';
- 'a uniform product costing model to calculate unit costs' for services such as laboratory tests and emergency patient transport; and
- 'appropriate rates for administrative and overhead expenditure' relating to the provision of health services and the management of the NHI Fund.

The committee will also be charged with 'implementing interim measures' to 'stabilise price determination mechanisms in the private health system' until such time as the NHI is fully implemented in 2025. It must also make recommendations for the establishment of a Health Care Pricing Authority which, in time, will 'enforce compliance' with all the prices laid down by the state and 'manage disputes arising from published final prices'.[97]

Ministerial Advisory Committee on Health Care Benefits for NHI

This committee will 'identify the disease burden' in the country and help develop norms and standards for the delivery of health care. As part of this last exercise, it will decide on the services to be 'excluded' in certain circumstances and on the 'waiting times' that will generally apply.[98]

> *The committee on healthcare benefits will 'identify the disease burden' in the country and help develop norms and standards for the delivery of health care. As part of this last exercise, it will decide on the services to be 'excluded' in certain circumstances, and on the 'waiting times' that will generally apply.*

In considering the likely costs of NHI benefits, the committee must 'use public service benefits as a point of departure' and find a way to manage 'on-going revisions to the costing' of healthcare benefits. It must also 'develop the purchasing strategies necessary to maximise the...affordability of health services' (though this, of course, will depend primarily on the prices that are set by the state). Though much data still has be to be gathered or updated –including information on 'current utilisation patterns' and 'the relationship between money spent and quality/utilisation/outcomes' – the committee is required to 'recommend a final benefit structure for implementation from 1st January 2018'.[99]

National Advisory Committee on the Consolidation of Financing Arrangements

This committee must 'make progress towards...the pooling of funds and purchasing of services', so as to help pave the way for 'the establishment of a single financing pool with a single purchaser'. It is to consolidate funding streams into 'five transitional funding arrangements', which will reduce fragmentation and increase 'income cross-subsidisation' without 'having to wait for the raising of additional funding through the tax system'.[100]

These five transitional funding arrangements are to cover the unemployed, the informal sector, bigger business, small- and medium-sized enterprises (SMEs), and civil servants (including those working for state-owned enterprises and the police, army, and intelligence). A key focus will be 'the consolidation of civil servants...into one financing arrangement', changes to the employer subsidy provided by the government, and the 'reform of the Government Employees Medical Scheme (GEMS) to 'align with the principles of NHI'.[101]

Through the work of this committee, 'mandatory cover and contributions' will be introduced for all those in formal employment. The Medical Schemes Act will be amended to 'consolidate existing restricted and

a Such a system classifies patients according to their diagnosis and sets a single fee for their conditions. This approach is seen as giving hospitals incentives to manage their costs better, as they may no longer charge fees for all services provided.

open medical schemes', and to introduce 'mandatory contributions' for employers and employees. Where appropriate, 'the state will provide a subsidy against the annual contributions, either upfront or through the tax credit system'. (This contradicts the White Paper's proposal to remove the tax credit, but the divergence is not explained. In addition, the introduction of mandatory medical scheme cover for those in formal employment was supposed to be 'implemented from the 1st of April 2017', a date which had already passed when the *Government Gazette* was issued.)[102]

The prescribed minimum benefits (PMBs) which all medical schemes must currently provide will be replaced with a 'comprehensive benefit structure'. Medical scheme members 'will [thus] see their current services expanded beyond PMBs to include the full range of services as outlined in the NHI package'. These changes are to be introduced by 1st January 2018.[103]

In 2017 'an advisory pricing commission will be established' and will make recommendations on the fees to be paid to both 'public and private providers'. During 2018 and 2019, 'a revised pricing and remuneration structure' for health services will be phased in. The committee (despite the absence of any clear statutory authority for its work) is to be 'responsible for the implementation of these reforms within the voluntary insurance sector'.[104]

Ministerial Advisory Committee on Health Technology Assessment for NHI

This committee will have multi-disciplinary expertise and will recommend what 'interventions' for diagnosing and treating disease should be 'prioritised' and 'selected'. It must also develop a 'prioritisation framework', which helps 'guide service selection' and is 'as explicit as possible about what services are included and excluded'. In doing so, it must 'ensure the cost-efficiency of mandatory benefits'.[105]

The terms of reference for these various bodies was gazetted without any opportunity for public comment. The composition of these structures has also been unilaterally decided, evoking strong objections from Cosatu and others. Their main complaint is that medical schemes and other private sector institutions are to be given significant representation on many of the new committees.

The committee will also make recommendations on the funding of a permanent health technology assessment (HTA) agency, identify the skills it will require, and develop 'appropriate training programmes' aimed at producing the requisite research and other staff.[106]

National Health Commission

The primary purpose of the National Health Commission is to develop and implement an 'all inclusive approach to the prevention and control of non-communicable diseases'. In doing so, it must 'comprehensively address the social determinants' of such diseases. It must also help ensure that all sectors within the government and civil society – including the private sector, trade unions, and non-governmental organisations – 'work collaboratively' towards preventing and controlling them. The commission must also develop 'relevant policies and interventions' to help achieve this goal.[107]

No public consultation on these bodies or their mandate

The terms of reference for these various bodies was gazetted without any opportunity for public comment. The composition of these structures has also been unilaterally decided by the Department of Health, evoking strong objections from the Congress of South African Trade Unions (Cosatu) and some non-governmental organisations. Their main complaint is that medical schemes, private hospitals, and other private sector institutions are to be given significant representation on many of the new committees. This, they say, raises the risk that the NHI proposal will be weakened and compromised through 'corporate capture'.[108]

Cosatu also objects to the fact that medical schemes are not to be closed down immediately but will instead be allowed to play 'a role in the transition to NHI'. An organisation calling itself the People's Health

Movement strongly opposes this too. It particularly criticises the proposal of 'mandatory medical scheme membership…for people in formal employment', saying this could entrench 'a multiple-payer' system which is still 'unequal and fragmented'. It has demanded to know whether the minister has abandoned the NHI vision, and instead plans 'to allow profiteers to pursue their own interests' and keep 'putting profits before people's health'.[109] (This stigmatisation of the private sector has passed largely unremarked by journalists and other commentators. Medical schemes and private hospitals have also remained silent, making no attempt to defend the important contributions they make to health care.)

Despite these criticisms of the minister for supposedly 'selling out' the NHI, it remains clear that the Department of Health regards any mandatory medical scheme membership that may be permitted as nothing more than 'an interim measure on the path to the NHI'. There is also little chance that Dr Motsoaledi will abandon his ideological hostility to medical schemes, which he sees as having been 'designed for a privileged minority at the expense of society'.[110]

(A recent article by Dr Paula Armstrong of Econex, an economics consultancy, notes the proposal for mandatory medical scheme membership, backed by state subsidies, in the July 2017 *Government Gazette*. It suggests that the Department of Health may thus be seeking to 'improve the affordability of medical schemes' and allow 'the private sector to play a supporting role in healthcare provision' under the NHI.[111] However, this suggestion disregards the department's emphasis on mandatory membership as an 'interim measure', along with the ANC's ideological aversion to private health care – and all that it has done to push the price of medical scheme membership beyond the reach of millions of people, as further outlined below.)

> *Despite these criticisms of the minister for supposedly 'selling out' the NHI, it remains clear that the Department of Health sees any mandatory medical scheme membership that may be permitted as nothing more than 'an interim measure on the path to the NHI'.*

The NHI Fund

In his budget speech in February 2017 the then finance minister, Pravin Gordhan, said that the NHI Fund was to be established during the course of the year. The fund would initially be financed by a reduction in the tax credit for medical scheme members. It would start with 'improving access to a common set of maternal, ante-natal, and family planning services'. It would also provide spectacles and hearing aids for school pupils, while improving services for the elderly, disabled, and mentally ill. 'These were priority areas identified by the minister,' said Treasury chief director for health and social development Mark Blecher.[112]

However, the NHI Fund cannot be created until enabling legislation has been adopted. The Department of Health said in July 2017 that it hoped to have the necessary bill approved by the cabinet in November 2017, but this now seems unlikely. In the October 2017 'mini-budget' (the medium-term budget policy statement), finance minister Malusi Gigaba said plans to establish the NHI Fund have been deferred until the Treasury has more information on how it should be financed. The proposal that current tax credits should be diverted to this purpose is under review, as the Treasury wants more data on the ramifications of this change (see *Current moves against medical schemes*, below). According to Mr Gigaba, a bill to establish the NHI Fund is still being drafted, while the Treasury and the health department are 'working on proposals to expand NHI services in a progressive and affordable manner'.[113]

Further interventions against private health care

The government has long been undermining private health care by pushing up access costs and narrowing service delivery options. Many of these regulatory interventions date back more than a decade and have already reduced the affordability of the private health system. Several further interventions of this kind have been implemented or announced since December 2016.

Earlier interventions

High reserve requirements

One of the regulations pushing up costs is the rule requiring medical schemes to maintain their reserves at 25% of gross annual contributions received. There is no scientific or actuarial foundation for this solvency ratio, which seems to have been arbitrarily chosen. In 2016 most schemes had solvency ratios above the set level, with the average ratio standing at 31.6%. (The exception was the Government Employees Medical Scheme (GEMS), the second largest medical scheme in the country, which had a solvency ratio of less than 10%. The government has long turned a blind eye to this shortcoming.)[114]

Because reserves have to be so high from the start, it is difficult for new medical schemes to establish themselves. The regulation also freezes an unnecessarily high proportion of premium income, leaving less available to pay for medical services. According to Jonathan Broomberg, chief executive of Discovery Health, South Africa's largest private medical scheme, 'medical schemes are currently sitting on R10bn in excess capital and reforms to the solvency requirements would immediately assist with the affordability of premiums'.[115]

One of the regulations pushing up costs is the rule requiring medical schemes to maintain their reserves at 25% of gross annual contributions received. There is no scientific or actuarial foundation for this solvency ratio. There is also no need for this reserve requirement when 're-insurance...could mitigate risks as effectively with less opportunity cost of capital'.

Mr Harris also cautions against the 25% reserve requirement. In a recent discussion paper for the High Level Panel of Parliament, he and Ms Price point out that the reserve requirement is unnecessarily high for large and well-capitalised schemes, but insufficient for small schemes that are under-capitalised. In addition, the money held in reserve is effectively 'dead capital', which cannot be invested to help meet health care needs. There is also no need for the reserve requirement when 're-insurance...could mitigate risks as effectively with less opportunity cost of capital'. Reinsurance cannot be used, however, because the government has prohibited this – in yet another damaging regulatory intervention.[116]

Open enrolment and community rating

Even more important in pushing up membership costs are regulations requiring 'open' enrolment and 'community' (or non risk-rated) premiums. Under these regulations, no prospective member may be turned away, irrespective of age or illness, or made to pay a higher premium (though limited 'late-joiner' penalties and waiting periods for existing conditions are allowed). This means that medical schemes must not only accept high-risk individuals, but also charge them the same premiums as low-risk people. The young and healthy thus have little incentive to join medical schemes, making for a risk pool of insured people who are older and less well. These factors drive up the monthly contributions required to cover costs and make membership of medical schemes increasingly expensive.[117]

These regulations were supposed to be offset by rules making it compulsory for all South Africans in formal employment to take out medical scheme membership. This would have compelled the young and healthy to join and helped reduce premiums for all. A 'risk equalisation fund' was also supposed to have been introduced, so that schemes with higher number of younger members could cross-subsidise schemes with higher numbers of older members. However, these additional interventions have not been made. As a result, most medical schemes have too many 'high-cost' members, which pushes up average premiums for everyone.

As earlier noted, the Department of Health has recently indicated that mandatory enrolment for those in formal employment is under consideration once again, 'as an interim measure on the path to the NHI' (as the department told delegates at a Board of Healthcare Funders conference in July 2017). Mandatory

membership could draw many more people into medical schemes and make it easier to reduce current contributions.[118] However, the impact of any such change is likely to be limited, as the government remains determined that medical schemes will no longer be needed once the NHI is fully in operation.

Prescribed minimum benefits (PMBs)

Further major cost pressures come from statutory provisions (in section 29 of the Medical Schemes Act and its accompanying regulation 8) which require all medical schemes to provide all their members with 'prescribed minimum benefits' (PMBs) for a host of specified conditions. Included on the PMB list are 270 medical conditions, such as cancer and pneumonia, along with 25 chronic conditions plus access to emergency care. Under Regulation 8, moreover, medical schemes must 'pay in full' for the treatment of PMB conditions. Every medical scheme member, irrespective of what cover they have signed on to receive, is entitled to these PMBs. This in turn means that medical schemes cannot offer membership at less than R800 per person per month, which is currently the minimum amount needed to cover the costs of these PMBs.[119] Again, this pushes up medical scheme premiums for everyone.

When PMBs were introduced, the rules indicated that medical schemes were required to pay for PMBs only if the services were provided at a state hospital, but this soon changed. Writes journalist Bronwyn Nortje in *Business Day*:[120]

> *In September 2015 the Council for Medical Schemes approved low-cost options that seemed set to make medical scheme membership affordable to some 15 million more people. These low-cost options were scheduled for introduction from January 2016 and were expected to have premiums as low as R180 a month for an adult member.*

'The result was that patients who had previously been treated at private hospitals under medical aid had to seek treatment at public hospitals which were quickly overwhelmed. The upshot was a skirmish between the medical schemes, their members, and the Council for Medical Schemes (a statutory body charged with regulating the medical schemes industry) over who should foot the bill. After some discussion and a court case, the registrar of medical schemes issued a circular stating that the provision of PMBs by a scheme is obligatory regardless of where the service is received.

'This was all well and good for the state hospitals, but it was the beginning of a lengthy tale of woe for medical schemes, which found themselves responsible for all costs – no matter how high – related to the treatment of PMB conditions. [This] open-ended liability caused havoc on their balance sheets. Apart from costing a lot more and making their risk more difficult to model, the legislation also created a perverse incentive for some providers to charge far higher rates to treat PMB conditions... These higher medical costs have simply translated into higher premiums. These higher premiums have in turn resulted in some people being forced to leave the schemes because they are unable to afford them. This has ultimately reduced medical scheme coverage.'

Low-cost medical schemes still barred

In September 2015 the Council for Medical Schemes responded to the affordability problem by approving low-cost options that seemed set to make medical scheme membership affordable to some 15 million more people. These low-cost options were scheduled for introduction from January 2016 and were expected to have premiums as low as R180 a month for an adult member.[121]

Costs were to be kept down by exempting these schemes from having to cover all PMBs, while members would be required to use state hospitals rather than private ones. At the same time, the schemes would provide a mandatory minimum package of primary services, including five consultations a year with a private general practitioner (GP), access to pre- and post-natal programmes, routine health screenings, and the provision of chronic and acute medicines. This in itself would reduce the burden on the state and

spare millions of people from having to spend hours or days waiting for such services at public facilities. (To prevent existing medical scheme members from 'buying down', the low-cost options would be available solely to people earning below the personal income tax threshold, then roughly R6 000 a month for people below the age of 65.)[122]

Soon, however, the council announced that it was suspending the introduction of these low-cost options until further notice. The announcement came two days after a meeting of the ANC's national general council (NGC), which had called for the urgent introduction of the NHI. This raised questions as to whether political interference had played a role in the council's sudden about-turn. Wrote Ms Nortje in *Business Day*: 'Two industry sources mentioned that the council received a call from the Department of Health following the NGC meeting, telling it to withdraw the low-cost benefit options immediately as they were considered a stumbling block on the path to the NHI.' Dr Motsoaledi denied this, saying that the low-cost options were 'an insult to low-income earners' and would not provide 'an acceptable level of care to members'. But the NHI scheme, with its enormous costs and limited capacity for delivery, would of course be much more difficult to justify if low-cost options were already available.[123]

The council has again been mandated to examine low-cost options to take the place of the primary health care insurance policies that are to be prohibited from April 2019 (see *Curtailing health insurance*, below). However, it remains doubtful whether these options will be developed or approved in the time available. Michael Settas, MD of KaeloXelus, a provider of health insurance and primary care products, says the two-year period envisaged is 'unrealistic', as the council has 'twice failed to implement the low-cost alternatives' that could have been introduced with the necessary will.[124]

> *The White Paper has added to the pressure on medical schemes by stating that current tax credits for medical scheme membership are to be removed. But the tax credit is important because it encourages people to join medical schemes. This increases the use of private health care and reduces the burden on over-stretched public facilities.*

Current moves against medical schemes

The White Paper has added to the pressure on medical schemes by stating that current tax credits for medical scheme membership are to be removed, and that all medical schemes are to be confined to providing a single prescribed set of health care benefits. Since then, Dr Motsoaledi has announced that government subsidies for public sector medical schemes are to be removed, that small public schemes are to be 'folded' into the large Government Employees Medical Scheme (GEMS), and that smaller private medical schemes with fewer than 6 000 members are to be terminated. Each of these proposed interventions merits further brief analysis.

Ending the tax credit

In the *2017 Budget Review* in February this year, the then finance minister, Pravin Gordhan, said the tax credit for medical scheme membership would be terminated to help pay for the NHI. At present, the tax credit reduces the amount of personal income tax (PIT) that taxpayers belonging to medical schemes would otherwise pay. The deductions permitted are small, but amount to some R3 600 a year for a principal medical scheme member and to more than R12 000 a year for a family of four. Overall, the tax credit results in the South African Revenue Service (SARS) collecting some R20bn a year less in PIT than it might otherwise do.[125]

The rationale for the tax credit is that it encourages people to join medical schemes, so increasing the use of private health care and reducing the burden on over-stretched public facilities. But Dr Motsoaledi claims that the tax credit is illegitimate because 'the money…is sent to people who are already rich, [when it should be used] to help those who are poor'. According to the minister, the tax credit constitutes 'the worst form of social injustice' – but is nevertheless being implemented with the government's 'full participation'.[126]

Dr Motsoaledi's analysis is false, however. Notes *Business Day* in an editorial: 'The minister argues that the tax credits given to medical scheme members essentially divert public funds into the private sector. But this is rubbish. Those rebates go to taxpayers who help pay for the public health system, but don't use it. These tax breaks were introduced to encourage more people to belong to medical schemes,...not to fleece the state.'[127]

Dr Motsoaledi's suggestion that the tax credits go only to the rich is equally mistaken. The tax credits go to all medical scheme members, including some 1.9 million lower paid people who rely on the tax credit to make their contributions affordable. Recent research by Econex shows that the poorest 20% of medical scheme members already spend 22% of their income on premiums. If the tax credit were removed, the sums spent on premiums would make up 35% of their salaries. This would make their premiums 'excessively expensive', notes Dr Armstrong, author of the Econex report. Most would find themselves with little choice but to withdraw from their medical aids. This would largely cut them off private health care and compel them to rely on state facilities instead.[128]

The government is now rethinking the issue. Delivering the medium-term budget policy statement in October 2017, Mr Gigaba said the Treasury needs advice from the Davis Tax Committee on the impact of reducing the medical tax credit. According to a recent Treasury analysis, in the 2014/15 tax year some 3 million taxpayers claimed tax credits (on behalf of some 8 million medical scheme members), resulting in a reduction of R18.5bn in the personal income tax that would otherwise have been paid. However, more than half (56%) of the total credits claimed that year went to 1.9 million taxpayers with annual taxable incomes of below R300 000. 'Tax data indicates that the programme is well-targeted to lower- and middle-income taxpayers,' Mr Gigaba noted. Wrote Tamar Kahn in *Business Day*: 'Although the Treasury does not directly say so, the data indicate that scrapping or sharply reducing the medical aid credits will hit people with lower incomes particularly hard, and potentially make their medical cover unaffordable.'[129]

> *The minister is also intent on removing the subsidies the government currently provides to millions of public servants to help them pay their medical scheme contributions. Dr Motsoaledi sees these state subsidies as an unacceptable drain on the fiscus. However, there are many public servants who rely on the subsidy to make medical aid affordable for them.*

Removing public sector subsidies

The minister is also intent on removing the subsidies the government currently provides to millions of public servants to help them pay their medical scheme contributions. Most public servants belong to state schemes, which range from the Government Employees Medical Scheme (GEMS) to the Police Medical Scheme (Polmed), the Parliamentary Medical Scheme (Parmed), the Municipal Workers' Union Medical Scheme, and Transmed. Some public servants also belong to private medical schemes, again with the help of the state subsidy. Overall, the medical aid subsidies paid to public servants and elected representatives, as part of their overall employment package, amount to some R27bn a year.[130]

According to Dr Motsoaledi, these state subsidies are an unacceptable drain on the fiscus and should instead be used to help fund the NHI. Though he again implies that these subsidies go solely to the wealthy, in fact some 45% of local government workers cannot afford medical aid membership – even with the help of a 60% subsidy from the state – because the 40% they would have to pay is too much for them.[131]

There are also many public servants who rely on the subsidy to make medical aid affordable. Public service unions have campaigned long and hard for these subsidies and have notched up some major gains in this sphere. As *Business Day* notes, one of the key demands in the last round of public sector wage negotiations was for a 28% increase in medical scheme subsidies for state employees in 2016, along with further inflation-linked increases in 2017 and 2018. Many Cosatu members in the public service, writes Dr Serfontein, would see their employee benefits package reduced by between R24 200 and R61 000 if

current subsidies were to be terminated. Public servants are thus likely to object strongly to the minister's proposal, irrespective of how much strongly Cosatu's leaders may support the NHI.[132]

One benefit option only

According to the White Paper, 'all benefit options in the various [medical] schemes will be consolidated from the current 323 benefit options in 83 schemes to one option per scheme'. The White Paper's figures seem outdated, however, for the number of medical schemes has come down to 82, following the amalgamation in October 2016 of the LMS Medical Fund ('Liberty') and the Bonitas Medical Scheme. The 82 remaining schemes include 22 open ones and 60 restricted schemes (where membership is limited to company employees, for instance). In 2016, open medical schemes had an average of 6.5 benefit options per scheme, compared to approximately two benefit options for the restricted schemes. As the Council for Medical Schemes reports, 'open medical schemes generally use benefit design as a mechanism to...improve marketability and competitiveness, [achieve] effective risk-pooling, or [create a] mechanism through which healthcare benefits are rationed and delivered'.[133]

According to the White Paper, the Medical Schemes Act is now to be amended to prevent medical schemes from offering more than one benefit option. This, it says, will ensure that 'medical schemes evolve and consolidate during this [implementation] phase to provide complementary cover'. (As earlier described, once the NHI is fully operative, medical schemes will be confined to providing cover that 'complements', rather than duplicates, the benefits available under the NHI.)[134]

The White Paper provides no clarity as to what the single option should cover. The director general of health, Dr Precious Matsoso, has said that 'the prescribed minimum benefits (PMBs) are to be replaced with a comprehensive set of services', which all medical scheme members will be entitled to access. These will have to be provided at the prices set by the state, so as to ensure that medical scheme members no longer run out of their annual benefits before the year is up. Says Dr Matsoso: 'Through NHI-inspired initiatives such as price regulation of medical service and the reductions of the cover options, we will ensure that those with medical aid cover are indeed covered throughout the year.'[135]

> *In 2016, open medical schemes had an average of 6.5 benefit options per scheme, compared to approximately two benefit options for the restricted schemes. The Medical Schemes Act is now to be amended to prevent medical schemes from offering more than one benefit option.*

However, medical schemes may battle to provide this comprehensive single package if their membership numbers start to dwindle as current tax credits and state subsidies are removed. According to Dr Matsoso, the government's price controls on medicines and provider fees will prevent this from happening.[136] In the real world, however, price controls are sure to lead to inefficiencies and costly distortions. They may also prompt an exodus of health professionals unwilling to work at unrealistically low fees, so limiting the health services that can in fact be supplied.

The government's determination to limit medical schemes to a single option also ignores the extent to which the low-income plans already offered by many open medical schemes are subsidised by mid- to high-end plans. In the words of Mr Harris and Ms Price (in their recent discussion paper on the NHI): 'In all of these schemes, the sick are [already] heavily cross-subsidised by the healthy, with top plans attracting the sickest members and running losses, which are subsidised by middle range plans which attract healthier members.'[137] Insistence on a single plan for every scheme will limit this cross-subsidisation.

Consolidation of medical schemes

According to the White Paper, the government will identify all the funding for medical schemes it currently provides (whether through tax credits or subsidies for state employees), and 'consolidate these into the NHI funding arrangement'. More recently, however, the minister has indicated that a different kind of consolidation is also envisaged. Smaller state medical schemes, such as Parmed, will be 'consolidated' into GEMS,

while smaller private medical schemes will be 'folded' into larger ones. However, it remains unclear how this is to be achieved, or what the legal and constitutional ramifications of these changes might be.[138]

According to Dr Motsoaledi, a key part of the implementation process is to 'reduce the number of medical schemes by merging them and abolishing many options that exist under many schemes'.[139] The minister remains adamant that all medical schemes will 'eventually be gone', once the NHI is in operation. 'This will be a process that takes years and, in the transition, there will be consolidation', he says. Once the NHI has been rolled out, the medical schemes that remain will 'all be collapsed into a single state-run medical aid plan', he stresses.[140]

This is also clearly what Cosatu leaders and organisations such as the People's Health Movement desire. However, ordinary public servants are becoming worried about this idea. Said Reuben Maleka, a spokesman for the Public Servants' Association, in September 2017: 'Members would prefer medical aids. We don't want to find ourselves in a situation where the NHI is the only option.'[141]

The Department of Health nevertheless remains intent on bringing about the proposed consolidation. The Council for Medical Schemes is thus considering dissolving some 30 medical schemes with fewer than 6 000 members, this being the minimum number schemes are required by law to have. Most of the affected schemes are restricted ones, in which membership is confined to employees rather than being open to the public. Among the schemes in issue are those provided by Afrox, AngloVaal, Barloworld, BMW, BP, De Beers, Engen, Tsogo Sun, and Tiger Brands.[142]

> *Once the NHI has been rolled out, the medical schemes that remain will 'all be collapsed into a single state-run medical aid plan', states the minister. But public servants are worried about this idea. Says Reuben Maleka, a spokesman for the Public Servants' Association: 'Members would prefer medical aids. We don't want to find ourselves in a situation where the NHI is the only option.'*

The Department claims that closing smaller schemes will 'create bigger risk pools' with better cross-subsidisation and lower premiums. But Barry Childs, a healthcare actuary, counters that restricted schemes often have 'better cross-subsidisation and offer better value'.[143]

Business Day journalist Tamar Kahn notes that 'more than 228 000 people' belonging to some 31 schemes could be affected by the change. Adds Ms Kahn: 'All but three of these schemes are restricted employer groups. Restricted employer groups generally subsidise members on low incomes, enabling them to buy cover they could not afford on the open market.' Other commentators have warned that lower-paid employees whose medical schemes are closed down – and who cannot afford similar benefits elsewhere – are likely to 'get dumped on the state'. This will add to the burden on the public healthcare sector. Dr Broomberg of Discovery Health notes that 'the legality of forcing small schemes to close' could also be an issue.[144]

Curtailing health insurance

On 23rd December 2016, in the midst of South Africa's festive season, the Department of Health and the National Treasury gazetted regulations aimed at limiting access to health insurance products of various kinds. These regulations are known as 'demarcation' regulations because they demarcate or identify health insurance products which the government wants to have treated as medical schemes and subjected to the onerous requirements of the Medical Schemes Act. The demarcation regulations generally took effect on 1st April 2017.[145]

The demarcation regulations have particular impact on primary health care policies, which have long been important in increasing access to private health care. In return for premiums ranging from R90 to R300 a month, these policies generally entitle people to a limited number of GP consultations, some acute and chronic medication benefits, and basic radiology, dentistry, pathology, and optometry benefits. These

policies are particularly popular with lower-income households unable to afford the high costs of medical schemes.

Medical schemes are more expensive for various reasons. First, as earlier noted, they are obliged by government regulation to provide cover for some 300 prescribed minimum benefits (PMBs), irrespective of whether people want these benefits or not. Since the average cost of providing cover for the PMBs is R800 a month, medical schemes generally cannot set their contributions below this amount. In addition, medical schemes are obliged to apply community rating, so that everyone pays the same irrespective of their health status, which further pushes up premiums for most people. Primary health care policies, by contrast, have not had to cover PMBs and have been allowed to apply risk rating, making this kind of health cover far cheaper than most medical schemes.[146]

Under the demarcation regulations, however, new primary health care policies have been prohibited since1st April 2017, unless they comply with medical scheme rules. Existing policies may, on application to the Council for Medical Schemes, be exempted from the demarcation regulations for two years, until April 2019. By then, low-cost medical scheme options are supposed to have been developed, so that existing primary health insurance policies can 'transition' into them (as the National Treasury puts it). However, it remains doubtful whether low-cost medical schemes will in fact become available within this period, as the council has thus far made little progress in implementing them.[147]

> *The principal effect of the demarcation regulations will be to deprive some 2 million people with primary insurance policies of access to private health care. By barring low-cost access to private treatment, the regulations will also help 'clear away the competition to the government's own proposed state health monopoly, the NHI', says the DA.*

The principal effect of the demarcation regulations, once they come fully into effect, will be to deprive some 2 million people with primary insurance policies of access to private healthcare. In the words of Richard Blackman, CEO of Day1 Health: 'People take up primary health care insurance because they want to access private health care but can't afford the conventional medical aid premiums, which are expensive. Now, the government is taking that right away from them and forcing them to either pay for medical aids or use the public health care sector. What is tragic is that the cheapest medical scheme options cost [at least] three times as much as what primary health care insurance policies cost.'[148]

The government argues that these insurance policies are harming medical schemes by attracting the younger and healthier people that medical aids need to help cover the treatment costs of the ill and the aged. This, it says, is pushing up the costs of medical scheme membership and undermining the viability of schemes. However, by barring low-cost access to private health care, the regulations also help 'clear away the competition to the government's own proposed state health monopoly, the NHI', as DA health spokesman Dr Wilmot James has written. Adds Dr James: 'If the government was genuinely interested in providing more and more South Africans with health coverage, they should support the expansion of the private health insurance sector. More and more citizens are taking it up because it works for them.'[149]

Other elements in the demarcation regulations could also be damaging. 'Gap-cover' insurance policies – which allow people to claim for the difference between what their medical schemes pays out for hospitalisation and what hospitals may in fact charge for in-patient care – are now limited to a maximum amount of R150 000 a year. The Treasury says that this restriction will have little practical impact as most gap cover claims are well below R150 000. However, the roughly 1.3 million South Africans who have taken out this supplementary insurance protection will no longer have a remedy if the gaps in their coverage in fact exceed this limit. In the past, moreover, gap claims have at times amounted to R300 000 or more, which is double the sum the regulations allow.[150]

Under the regulations, hospital cash plans – which pay out specified amounts for periods spent in hospital – are to be limited to R3 000 a day or a lump sum of R20 000 a year. The risk rating which previously applied here has also been abolished. This means that insurance companies can no longer use factors such as age and claims history to decline cover, or to decide on the premiums that individuals should pay. In the face of these limitations, Hollard – one of the biggest insurance companies operating in this sphere, with 150 000 hospital cash plans on its books – said it was busy 'evaluating the regulations to decide if it was possible, and sensible, to continue offering hospital cash plans' at all.[151]

The impact of the demarcation regulations is likely to be considerable, warns Mr Settas of KaeloXelus. The regulations will 'dictate what health care products insurers can market and under what conditions'. The conditions now stipulated by the state, he adds, are likely to be as 'inflationary and unsustainable' as those governing medical schemes have already proved to be.[152]

The burden of government regulation has increased steadily since 1998, when the Medical Schemes Act was adopted. Now many of the same costly requirements have been extended to the low-cost health insurance products on which millions of South Africans have come to rely. The predictable effect of the state's interventions has been to push up medical scheme premiums and make it more costly for people to gain access to private health care. Medical schemes, faced with unrealistic reserve requirements, increased utilisation by an ageing population, and the costs of having to cover PMBs for all their members – including those on the cheapest options – have had to raise their premiums while cutting back on the benefits they provide. The combination has helped fuel a popular anger at medical schemes and the private health sector, which the government's own propaganda has also greatly fostered.

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Stigmatising private health care

The ANC is ideologically hostile to business and has long demonstrated a deep suspicion of the 'profit' motive in private health care. Both for this reason – and to help pave the way for its damaging regulatory interventions – it has repeatedly stigmatised the private health care system as costly, selfish, and uncaring in its supposed constant drive to put 'profits before people'.

The ruling party takes the view (as Dr Manto Tshabalala-Msimang, minister of health in both Mbeki administrations, once put it) that the private health care system is little more than 'a ravenous monster that preys on our people'. Dr Motsoaledi also seems driven by an ideological fervour against the private healthcare sector, which he has repeatedly stigmatised as intent on profiteering and extortion.

In 2011, for instance, the minister lashed out at the private health care system, blaming it for poor healthcare outcomes and saying it was 'unsustainable and destructive'. He was particularly scathing about private hospitals, saying they 'extorted money' from medical schemes and their members. They also raised the cost of health care 'arbitrarily and unfairly'. Hence, he said, his best advice to anyone who yearned to be a billionaire was 'not to own a mine but a private hospital'.[153]

Also in 2011, the minister blamed the private sector for 'a predatory health care system where the sick and the vulnerable are the ones who get attacked.' In 2012, while acknowledging that public hospitals were in a parlous state, he added that a large part of the public sector's problems stemmed from 'rampant commercialisation in medicine'. This led to ever-rising prices, which reduced the number of people able to afford private care and increased the burden on the public sector. He blamed rapid increases in the fees charged by private hospitals on the 'over-provision' of medical services, along with unethical practices such as over-

charging for surgical supplies and materials. He also poured scorn on the suggestion that prices were rising because medical scheme members were getting older and needing more expensive treatment. Instead, as *Business Day* commented, he continued to claim that the main cause of soaring medical inflation was 'private-sector greed'. Since then he has continued to castigate the private system, recently describing the mere 'existence' of medical schemes 'as a punishment for poor people'.[154]

Dr Motsoaledi has also repeatedly stressed the supposedly enormous differences in the fees charged by private and public hospitals. In 2012, for instance, he stated that private hospitals charged R150 000 for a spinal decompression, whereas the Steve Biko Academic Hospital in Pretoria charged only R30 000. In addition, private hospitals charged R15 000 for circumcisions, he said, whereas township clinics charged 'only a few rand'. But Garth Zietsman, a statistician, disputed the comparisons cited and said they were 'probably chosen to be maximally misleading'.[155]

According to Mr Zietsman, the minister had failed to mention the huge state subsidy, paid by taxpayers, that financed public health. He had also overlooked the fact that private hospitals had to pay their own land, construction, and maintenance costs, whereas the Department of Public Works generally covered such expenses for public hospitals. The minister had further failed to acknowledge that there could be differences in the conditions involved: most circumcisions were straightforward, but some were not. Spinal decompression could be done in different ways, depending on particular needs, and some were more complex than others. On a more appropriate comparison, added Mr Zietsman, private hospital costs were on average only 1.4 times more expensive that public hospital costs. If all relevant factors were taken into account and like was more strictly equated with like, then private hospital costs were a mere 1.1 times those of public hospitals.[156]

Behind this constant stigmatisation of private health care lies the ANC's commitment to the national democratic revolution (NDR). The ANC first embraced the NDR back in 1969, when it was strongly under the influence of its Soviet mentors. The Soviet ideologues who helped develop the NDR doctrine have long since repudiated it, but the ANC and its allies remain deeply committed to it.

Behind this constant stigmatisation of private health care lies the ANC's commitment to the national democratic revolution (NDR). The organisation first embraced the NDR back in 1969, when it was in exile and strongly under the influence of its Soviet mentors. Though close on 50 years have passed still then, the ANC has recommitted itself to the NDR at every one of its national conferences since 1994, including its most recent one at Mangaung (Bloemfontein) in December 2012.[157]

The NDR concept was developed by the Soviet Union in the 1950s, so as to help push newly independent colonies in Asia and Africa into transforming their capitalist economies into socialist ones. The Soviet ideologues who helped develop the NDR doctrine have long since repudiated it, but the ANC and its allies in the South African Communist Party (SACP) and Cosatu remain deeply committed to the NDR and determined to implement it as rapidly as circumstances allow.[158]

The ANC is deliberately vague about the NDR's ultimate objectives. However, the SACP and Cosatu openly describe the NDR as offering the 'most direct' path to a socialist and then communist future. The real aim of the NHI is to help achieve this goal by:

- dislodging business from a key sphere of market-based provision;
- giving the state control of all private healthcare resources, thereby effectively nationalising them;
- establishing the principle that private spending must be pooled with public revenues for the benefit of those in need,
- using the NHI precedent to extend this principle to other important areas, including education and pensions, where proposals for a government-controlled pensions fund have been put forward; and

- consolidating mass dependency upon the government.

So important is the NHI to the NDR that in 2009, when the ANC brought out a lengthy discussion paper on the proposal, SACP general secretary Dr Blade Nzimande went so far as to threaten 'war' against all NHI opponents. Said Dr Nzimande: 'The capitalist classes have already started a huge campaign in the media to try to discredit this system and we want to say to them as communists today, war unto you.' He vowed that workers would 'meet capitalists in the streets' and warned them to 'prepare for a huge battle because we are going to mobilise the workers and the poor of the country to fight against you'.[159]

Like the SACP, Cosatu is also 'gearing up for a fight with the middle classes' if they oppose the NHI and try to stop it. Said Mike Shingange, first deputy president of the National Education, Health and Allied Workers' Union (Nehawu) in January 2016: 'We don't believe in medical aids, just like we don't believe in private hospitals.' He reiterated that health care is a 'human right' and cannot be provided by 'a business for profit'.[160]

In 2017, with the ANC now seeking to forge ahead with implementing the NHI, the minister has often reiterated the same flawed arguments for its introduction. This frequent repetition of the same key themes is part of a propaganda campaign aimed at distorting reality, isolating opponents, and building popular support for the NHI. Five themes are being emphasised in particular:

- that public health care system has 'systematically been stripped of resources – both human and financial – as these have been directed at the private sector';[161]
- that the public sector is able to spend only 4% of GDP on health care but has to provide care to 'a whopping 84% of the population';[162]

Dr Motsoaledi repeatedly blames the current 'two-tier system', with its private and public elements, for all the weaknesses in health care in South Africa. His frequent repetition of the same key themes is part of a propaganda campaign aimed at distorting reality, isolating opponents, and building popular support for the NHI.

- that massive sums, amounting to '4.4% of GDP', are being devoted to the health needs of a mere 16% of South Africans;[163]
- that the private sector lures healthcare practitioners away from the public service, leaving only 20% of all specialists to serve 84% of South Africans;
- that the 16% who benefit from private health care are resisting the NHI because they 'do not want equity with regard to healthcare provision' or for 'poor people to "invade" their space'.[164]

Dr Motsoaledi also repeatedly blames the current 'two-tier system', with its private and public elements, for all the weaknesses in health care in South Africa. He further claims that medical schemes have 'siphoned huge amounts from the public purse' through subsidies and tax rebates, that this has profoundly 'compromised the efficiency...and quality of the public healthcare sector', and that 'this subtle and steady re-allocation of resources to the haves started in 1967 with the proclamation of the first medical scheme... as a whites-only system'. In similar vein, he states that the NHI is the best way to 'reverse the apartheid planning that sought to condemn the majority of people to ill-equipped and under-staffed hospitals while the minority, the rich, had exclusive use of the best medical facilities in the country'.[165]

This assessment seems calculated to whip up popular outrage at the existing system. However, there are a host of fallacies and other flaws in the minister's analysis. To begin with, the noxious racial laws that barred black people from the well-resourced public hospitals reserved for whites have long since vanished. In addition, even in the apartheid era, public hospitals in Soweto and elsewhere provided a high standard of care. In addition, the tax system is highly progressive and there has long been a large amount of redistribution via the budget, which has accelerated since 1994.

At present (as earlier noted), some 62% of personal income tax is paid by some 560 000 people, most of whom get little back from the fiscus in return. The tax credit, though relatively small, helps millions of households to join medical schemes and access private health care, thereby reducing the burden on state facilities. Private health care is funded primarily from people's after-tax salaries and does not infringe on the resources available to the public sector. Those resources are also considerable, for they amount to 4% of GDP and compare well with what most other emerging markets are able to spend on public health care. The key problem, however, is that available tax revenues are often badly used because of limited skills, poor management, and widespread financial irregularities in the public healthcare system.[166]

It is also inaccurate to assert that the private health system serves only 16% of the population, when some 30% of South Africans on average rely on private practitioners: 16% of them through their medical schemes and the remaining 13% by making out-of-pocket payments as the need arises. In addition, more detailed utilisation figures show that 62% of South Africans rely on public sector nurses, as opposed to the 38% who rely on private sector nurses. Similarly, 63% of the population consult public service GPs, while 37% use those in the private sector.

The split between public and private hospital beds is also very different from what the minister suggests, for the public health sector has some 86 770 beds (72% of the total), while the private health service has roughly 34 570 beds (28% of the total). The number of beds in public hospitals has also steadily diminished since the 1970s – and it is only because the private sector has increased its hospital beds that the overall number has remained much the same.[167]

> *It is misleading to claim that 80% of specialists work in the private sector, when the correct proportion is 59%. In addition, many of the specialists working in private practice cannot find posts in the public service because its 'entire focus is on primary healthcare'.*

It is also misleading to claim that 80% of specialists work in the private sector, when the correct proportion is 59%. In addition, many of the specialists working in private practice cannot find posts in the public service because it has reduced the funding that used to go to tertiary hospitals in order to concentrate on primary care. 'The entire focus is on primary healthcare to the detriment of specialist services,' says Dr Mvuyisi Mzukwa, head of the KwaZulu-Natal coastal branch of the South African Medical Association. 'The government's policy is to spend money on clinics and nurses, and improve the basic health system so fewer people needed specialist treatment.'[168] Hence, if specialists did not have the option of practising in the private sphere, many would have little choice but to emigrate – and their skills would then be lost to the country altogether.

The minister's claim that the private sector 'steals' public sector staff is equally false. In the period from 2002 to 2010, for instance, some 11 700 doctors graduated from the country's various medical schools. In the same period, however, the number of public sector posts increased by only 4 400, making it impossible for some 7 300 of these new graduates (62% of the total) to find work in the public sphere. There was thus a 62% 'retention gap' in the public sector's capacity to absorb these new doctors. The same phenomenon is evident in dentistry (where the retention gap over the same period was 88%), in physiotherapy (where it was 83%), in audiology and speech therapy (where it was 81%) and in pharmacy (where the retention gap was a relatively small 46%). These figures show that the public sector has a limited capacity to absorb the medical skills that South Africa produces. In many instances, if the private health sphere had not been available as an alternative source of jobs, many of these health graduates would probably have found work in other countries.[169]

Dr Motsoaledi has sometimes also claimed that private medical scheme members are 'dumped' on state hospitals once their annual benefits have been used up. But this too is false. Almost all private medical schemes offer extensive hospital cover, making it extremely rare for private medical scheme members to run out of these benefits and turn to the state instead. What dumping takes place is in fact generally the

other way around. As Mr Harris and Ms Price record: 'The very poor state of hospital care...forces the poor with severe illness, such as chronic renal failure or cancer, to join private medical schemes to get access and stay alive. The keystone example of this is dialysis. It is virtually impossible to get access to dialysis services in the state. Thus, anyone with renal failure is told by doctors to join a scheme – and, as there are limited underwriting protections, these patients soon have dialysis fully covered at a relatively low monthly premium for them.'[170]

Despite all the evidence to the contrary, the propaganda campaign against private health care persists. Moreover, it is not only the minister who contributes to the stigmatisation. In February 2017, for instance, the president of the Health Professions Council of South Africa (a statutory body committed to protecting the public and guiding the professions), Dr Kgosi Letlape, said the NHI could not coexist with medical schemes, as these were 'a crime against humanity and an atrocity'. He added that there were 'between 3000 and 4000 medical professionals working for medical schemes that could be redistributed to the health system if schemes were abolished'. Commented Jasson Urbach of the Free Market Foundation: 'That Letlape does not think that medical schemes are part of the health system is revealing in and of itself. But his view that people can be "redistributed" harks back to a Soviet form of social engineering and has no place in a democratic state.'[171]

The head of communication at the Department of Health has also endorsed the minister's false claim that only 16% of South Africans have access to private health care, dismissed well-founded criticisms of the NHI as 'deliberate misinformation', and called on departmental officials to ready themselves for a 'war' against those who question the proposal. Cosatu continues to insist that the private sector must be excluded from any role in the NHI as its 'profit motives would always be placed above patient needs'. As earlier noted, Cosatu has also accused the minister and his department of 'going rogue' by suggesting that private medical schemes should be retained until the NHI is fully functional. This, says Cosatu, will 'enable the continuation of the two-tier system' in which the poor get the dregs and the rich cream off the most.[172]

There no need for a 'revolution', or for a new system to be hammered together in 'blood and pain', when a number of incremental reforms would allow South Africa to achieve universal health coverage in far more effective ways. Various concrete alternatives have also been proposed.

Dr Motsoaledi has vigorously denied Cosatu's charge, while continuing to blame the private sector for the public sector's ills. According to the minister, the government has no intention of 'segregating 84% of South Africans in public hospitals'. Nor will it allow 'more [money] to be spent on just 16% than on all the rest' of the population. The government is thus determined to press on with the NHI, which will be 'a revolution in the provision of health', he says. It will do so irrespective of the costs, the minister implies, for 'revolution, like birth, is characterised by blood and pain'.[173]

However, there no need for a 'revolution' or for a new system to be hammered together in 'blood and pain' when a number of incremental reforms would allow South Africa to achieve universal health coverage in far more effective ways. Various concrete alternatives have also been put forward. These generally seek to harness the strengths of the private health care system, while rebuilding the capacity of public health care, increasing the supply of doctors and other providers, encouraging competition and innovation, and extending efficient health services to all South Africans.

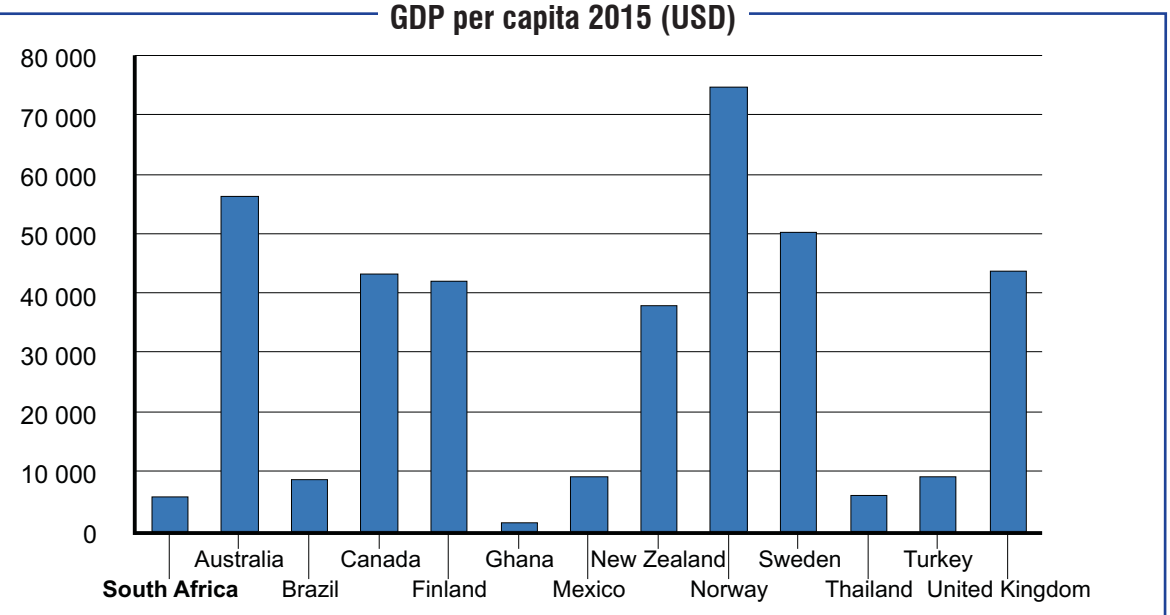
Alternatives to the NHI proposal

In the past year, Dr Motsoaledi has frequently accused critics of the NHI of wanting to retain an unfair system and deprive South Africans of the benefits of universal health care (UHC). This accusation is false. It is not the UHC goal that critics oppose, but rather the inability of the NHI to achieve it. Critics also point to the folly of insisting on the NHI as the only way to proceed when better alternatives are readily available.

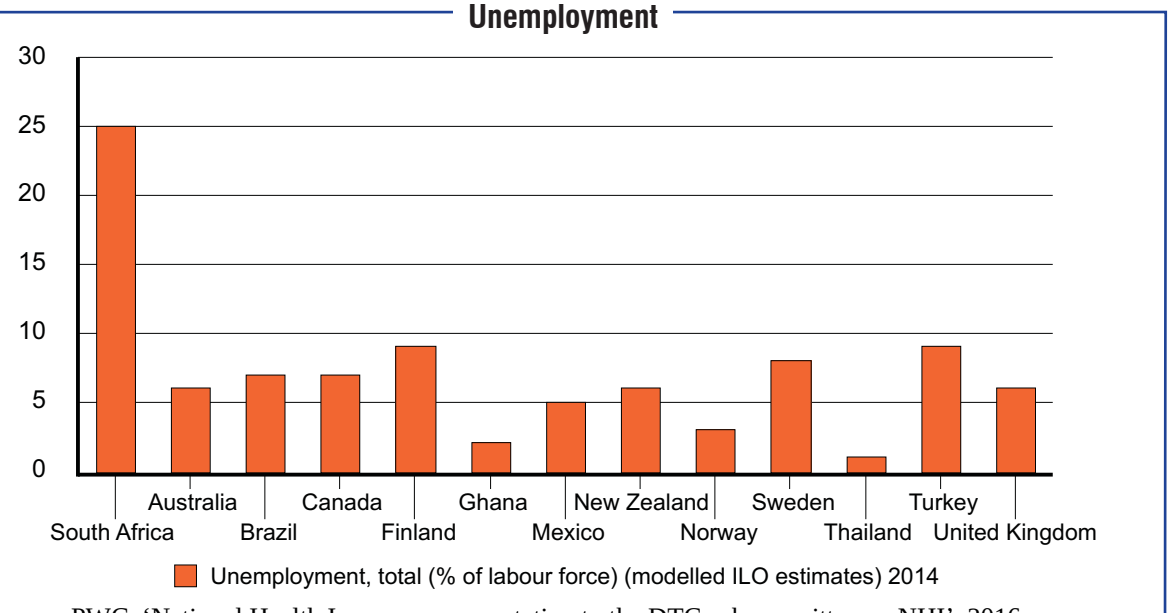
The World Health Organisation on universal coverage

According to the 2015 draft of the white paper, the World Health Organisation (WHO) is 'encouraging' countries to move towards 'universal health coverage' (UHC). This is also one of the Sustainable Development Goals the WHO hopes to see achieved by 2030. According to the WHO, UHC is intended to ensure that 'all people can use' the health services they need. These services should also be 'of sufficient quality to be effective', and should 'not expose their users to financial hardship'.[174]

The WHO's recommendations regarding UHC are thus more tentative than Dr Motsoaledi seems willing to allow. According to the minister, South Africa has no choice but to adopt the NHI because the WHO insists on member countries introducing UHC. This distorts what the WHO has in fact said. It also obscures the fact that relatively few nations have introduced UHC – and that almost all the countries which have done so have far greater wealth, workforces, and tax bases on which to draw.



Source: PWC, 'National Health Insurance, presentation to the DTC subcommittee on NHI', 2016



Source: PWC, 'National Health Insurance, presentation to the DTC subcommittee on NHI', 2016

Moreover, the WHO does not prescribe to member states how UHC is to be achieved. It recommends that countries should find ways to 'pool funds,…so as to spread the financial risks of illness across the population' and avoid crippling health care costs for both the poor and the rich. It also stresses that nations must choose the systems which suit them best – and that whatever option is adopted must be affordable in the long term. In addition, the WHO categorically states that *'universal health care does not mean free coverage for all possible health interventions, regardless of the cost, as no country can provide all services free of charge on a sustainable basis'*.[175] The NHI system proposed by the minister thus goes far beyond what the WHO envisages or recommends.

Basic principles for an effective UHC system

In devising a better UHC alternative, the first aim must be to develop a system that is workable, financially sustainable, and in keeping with WHO recommendations. Such a UHC system must aim to preserve South Africa's private healthcare system, while giving all South Africans access to its benefits. A new UHC system must also aim to improve efficiency within the public healthcare sector, while ensuring that the country gets much more bang for its already extensive healthcare buck.

In addition, a new UHC system must seek to expand the supply of health professionals and health facilities. It must also find innovative and creative ways to extend the reach of limited resources. At the same time, it should not allow the rationing of health services by price to be replaced by the rationing of health care by waiting time, as this is no advance at all. A new UHC system must also avoid the effective nationalisation of private health care and be in keeping with the Constitution.

> *The World Health Organisation (WHO) categorically states that 'universal health care does not mean free coverage for all possible health interventions, regardless of the cost, as no country can provide all services free of charge on a sustainable basis'.*

Five critics of the NHI have used these basic principles to develop proposals for efficient and affordable UHC systems that will be far more effective in meeting the health needs of all South Africans. These proposals are briefly set out below (in no particular order) so as to show what could be achieved if the government were less rigid in its ideological commitment to the NHI.

South African Private Practitioners' Forum (SAPPF) Proposal (Option 1)

The South African Private Practitioners' Forum (SAPPF) is a voluntary association of some 2 700 specialists practising in the private health care sector.[176] It recommends, in essence:

1.1 The introduction of low-income medical schemes (LIMS) (at a cost of some R380 per person per month), accompanied by mandatory cover for all employees in the formal sector and the use of a risk equalisation fund for medical schemes to further pool risk. Employees should be asked to pay R100 per person per month, while employers should fund the difference in return for a tax credit. Some 18m South Africans would then belong to private medical schemes and would have access to private health care in the same way as everyone else. This would counter adverse selection, draw the young and healthy into medical schemes, and make it possible for monthly premiums to be reduced by some 20%. However, this saving, currently amounting to some R26.6bn, would not be passed on to medical scheme members but would instead be used to finance a Revised NHI Fund (R-NHI Fund), as described at 1.3 below;

1.2 The introduction of mandatory gap insurance cover for all formal sector employees, to help cover unforeseen medical expenses and heavy hospital fees that could otherwise cause financial hardships. Monthly premiums (given the size of the risk pool) could be limited to R80 per person per month, of which employers would pay half;

1.3 The Revised NHI Fund (R-NHI) should use the R26.6bn in savings (generated under 1.1) to fund private primary health services for poor people who currently rely on the public health sector. This would reduce the burden on the public sector and give the poor access to the benefits of private care, at least at the primary level. (Secondary and tertiary services would still be sourced from the public sector.) Private providers of health services to the poor would be paid on a capitation, rather than a fee-for-service, basis to help reduce costs. The R-NHI Fund would be administered by private medical scheme administrators, who would be appointed for five-year terms under a transparent and objective tender process;

1.4 The R-NHI Fund would take over the functions of the Workmen's Compensation Fund, giving it an additional R8bn in annual contributions, along with reserves of some R54bn. The R-NHI Fund would assume responsibility for paying the medical claims that are currently so poorly handled by the Compensation Fund;

1.5 The R-NHI Fund would also pay the medical claims of the victims of road accidents, and recover these costs from the Road Accident Fund;

1.6 The R-NHI Fund would also contract with private specialists, who would help to meet key needs (gynaecological consultations and radiology services, for instance), while also carrying out procedures for which there are currently long waiting periods in public health facilities (such as hip replacements and cataract operations). These specialists would form part of an agreed network, under a managed care approach, and would be paid on the basis of global fee arrangements to help contain costs;

1.7 Various steps should be taken to help reduce private sector costs in general: for example, by making greater use of emergent technologies and alternative reimbursement models; while

1.8 The burden on the public sector would be much reduced in these circumstances, making it far easier for public health facilities and practitioners to provide efficient and effective services within the limits of the tax revenues currently available for public health care.

The Revised NHI Fund should use this R26.6bn to fund private primary health services for poor people who currently rely on the public health sector. This would reduce the burden on the public sector and give the poor access to the benefits of private care at the primary level.

Paul Harris/Julia Price Proposal (Option 2)

Mr Harris and Ms Price, in their discussion paper for the High Level Panel of Parliament, put forward similar, albeit less detailed, proposals. They suggest:[177]

2.1 Private medical schemes should remain in place, as should GEMS, while the unemployed and destitute should be serviced by a new NHI Fund;

2.2 A package of 'minimum NHI services' should be decided by the government;

2.3 Fees for the defined minimum NHI package should be negotiated between providers, medical schemes, and the NHI Fund, as this will allow 'an acceptable set of initial prices and acceptable annual price increases to be agreed, without creating the risk of a mass exodus of health professionals';

2.4 All medical schemes should be required to carry the NHI minimum package, but schemes should be free to offer other benefits so as to encourage choice and competition;

2.5 The NHI Fund should be funded by the government out of tax revenues and would provide the NHI minimum package to the poor and unemployed, but at a cost far below the R256bn the White Paper envisages;

2.6 Membership of medical schemes, at least as regards the minimum NHI package, should be mandatory for all in formal employment;

2.7 Risk equalisation between private medical schemes, GEMS, and the NHI Fund should be used to spread risk and ensure adequate cross-subsidisation. In this way, a 'virtual' central fund would share the financing burden within a multi-payer system. This would be far more efficient and far less risky than establishing 'a single payer with a physical pooling of capital, management, and governance';[178]

2.8 The private sector should be used to train many more doctors, nurses, and specialists, while the Cuban training programme for doctors should be terminated;

2.9 Hospitals should be allowed to employ doctors and specialists (as this would help reduce the overhead costs these providers now have to cover), as should medical schemes and managed care organisations;

2.10 Management of public hospitals must be improved, while responsibility for key functions (such as procurement and personnel appointments) should increasingly be devolved to well-run institutions as their capacity grows;

2.11 Other steps must be taken to 'build excellence in the public sector' and encourage efficiency and innovation in all aspects of health care; and

2.12 The arbitrary 25% capital reserve requirement should be replaced by the use of re-insurance policies, which the government currently prohibits.

> *Every South African citizen and legal resident should be entitled to a health subsidy from the state, which should be enough to cover what 'an affordable and comprehensive package of services' within the public health system would cost. All persons should be able to buy public or private sector cover with their subsidies.*

Democratic Alliance (DA) Proposal (Option 3)

The official opposition, the Democratic Alliance (DA), has put forward an alternative UHC model which again has many similar features. The DA concept is sometimes poorly worded (making it difficult to understand), but its most important elements are as follows:[179]

3.1 Every South African citizen and legal resident should be entitled to a health subsidy from the state, which should be enough to cover what 'an affordable and comprehensive package of services' within the public health system would cost;

3.2 All persons should be able to buy public or private sector cover with their subsidies;

3.3 The subsidy should be funded by reallocating part of the current health budget, terminating the medical aid credit (worth R17.4bn in the 2017/18 financial year), and using a portion of the latter amount;

3.4 Medical scheme benefits should be standardised in line with this 'public sector package of services', and medical schemes should receive a subsidy per person equivalent to the average per capita cost of the standard package. However, schemes should be allowed to offer top-up cover for which medical scheme members would pay out of their own pockets;

3.5 Risks should be spread via a risk equalisation fund, coupled with state-sponsored reinsurance for small schemes;

3.6 Mandatory medical scheme membership should be considered for 'employers above a certain size', so as to counter the current anti-selection risk;

3.7 Public health services should be free at the point of delivery for those who have medical aid

membership as well as those who do not, while the means test for free or subsidised treatment in public facilities (which has recently been increased from R100 000 in annual household income to R350 000 a year)[180] should fall away;

3.8 An additional R6bn in tax revenues (to be garnered from the remainder of the erstwhile medical aid credit) should be allocated to improving maternal and child health, building more public clinics in under-serviced areas, creating an integrated public/private emergency service to be accessed via a single national telephone number, and expanding training for doctors, nurses, and other providers;

3.9 'Fit-for-purpose' civil service appointments should be secured through a decentralised and professionalised process, shorn of 'discretion for political appointments';

3.10 Hospitals and other public health facilities should have significant autonomy and should be properly managed by 'clinically trained chief executives' and independent boards;

3.11 An Information and Technology Regulator should be established to help provide information on all parts of the health system, both public and private, and give the public access to data on the quality and price of every service;

3.12 The Council of Medical Schemes should be 'firewalled from political interference' and appointed independently of the minister, while the OHSC should be replaced by a Quality of Care Regulator which would define the 'standard package' funded by the universal subsidy and audit the quality of care provided by all public and private health facilities; while

3.13 The main focus should fall on primary health care as the country's 'disease profile shows that most South Africans become ill from, or die of, preventable diseases that are manageable at the PHC tier and can be treated [there] at significantly lower cost than at second-tier hospitals'.

Any UHC policy must begin by recognising that the continuation of private health care, with its significant financial and human resources, is 'of vital importance to South Africa's overall health and welfare'. The focus should also be on getting more people into jobs and increasing current tax credits, so more households can take advantage of private health care.

The Free Market Foundation (FMF) Proposal (Option 4)

The Free Market Foundation (FMF) stresses that a UHC system should concentrate on the needs of the poor, while rolling back damaging regulatory interventions and 'allowing the private sector to grow, innovate, and expand'.[181] The FMF adds:[182]

4.1 Despite the opposition of health activists and others, South Africa should recognise the great importance of the private sector in contributing to UHC. In the words of Professor Dominic Montagu, associate professor of epidemiology at the University of California, San Francisco: 'The idea that involving the private sector is antithetical to UHC is bizarre... More than two-thirds of all OECD countries rely mostly on private out-patient care and some of the best performing countries also deliver the majority of in-patient care through private hospitals... In addition, the private sector provides up to 80% of healthcare in many developing countries';[183]

4.2 Any UHC policy must begin by recognising that the continuation and expansion of private health care, with its significant financial and human resources, is 'of vital importance to South Africa's overall health and welfare';

4.3 Rather than increasing taxes on an already overburdened tax base to fund the NHI, the focus should be on getting more people into jobs and increasing (rather than removing) current tax credits so that more households can take advantage of private health care;

4.4 To increase affordability and access, the government should remove the value-added-tax (VAT) currently charged on medicines and medical devices;

4.5 To increase the supply of health practitioners, the government should ease its restrictions on the employment of foreign health professionals and allow the private sector to train doctors, nurses, specialists, and other providers;

4.6 Employees in the formal sector with incomes above a means-tested threshold should be required to purchase health insurance from a range of private insurers and medical schemes, which would compete for their custom on cost, efficiency, and innovation;

4.7 The government should focus its efforts on those who cannot afford to take out cover of this kind. It should use tax revenues to provide them with the funds they need to pay medical scheme contributions or health insurance premiums. It should 'act as financier', but let people decide for themselves what schemes or policies they would prefer;

4.8 'In the same way as people have many options to choose from in household insurance, car insurance and a myriad of other products and services, publicly-funded patients would then have a multiplicity of private medical schemes and insurers to choose from. Competition between public hospitals and clinics, and with private facilities, to win business from taxpayer-funded public health insurance beneficiaries would thrive, and would ensure that the best service for the best price is given';

4.9 The government should recognise that 'it is not necessary for it to finance the healthcare needs of the entire population' and that 'to do so would not be a...good use of scarce taxpayer resources';

4.10 The government should 'systematically deregulate' the private healthcare sector and repeal many of the regulations which have pushed up the price of medical scheme membership and made this increasingly difficult to afford. In particular, it should put an end to open enrolment, community rating, compulsory cover for some 300 prescribed minimum benefits, and the arbitrary 25% capital reserve requirement; while

4.11 The focus must be on incremental reform, for 'if many small steps are taken, the positive effects have a better chance of succeeding, while the negative ones would be easier to undo'. By contrast, 'if one giant leap' is taken – especially the 'massive reorganisation' the White Paper says the NHI will require – this could have far-reaching consequences that are 'drastic and disastrous'.

> *The government should use tax revenues to provide the poor with the funds they need to pay medical scheme contributions or health insurance premiums. It should 'act as financier', but let people decide for themselves what options they would prefer. Publicly-funded patients would then have a multiplicity of private medical schemes and insurers to choose from.*

IRR Proposal (Option 5)

The IRR has also suggested a UHC model, based on the following core ideas:

5.1 Open enrolment, community rating, and compulsory cover for some 300 prescribed minimum benefits (PMBs) have resulted in some 90% of medical scheme members paying monthly contributions that far exceed the actuarial risk they pose and their own health needs. Risk rating should be re-introduced to bring down premiums for the great majority, while schemes should no longer be obliged to cover all PMBs;

5.2 All medical schemes should include 'health savings accounts' (HSAs), into which members pay a portion of their monthly contributions and which they own and control. In the United States, where HSAs are common, providers competing for the custom of patients with HSAs have found many

innovative ways to improve delivery and hold down costs. These include mail-order pharmacies and walk-in ('minute') clinics in shopping malls;

5.3 Low-cost medical schemes should be introduced for those in formal employment who earn below the personal income tax threshold (currently some R6 300 a month), and at monthly premiums of roughly R360 per person. PMBs would not be covered, but members would be entitled to hospital benefits and would receive a minimum package of primary services (including a limited number of general practitioner (GP) consultations, some acute and chronic medication benefits, and basic radiology, dentistry, pathology, and optometry benefits). Employees would pay a third (R120) of the monthly premium, while employers would pay the balance and receive an equivalent tax credit, along with points on a voluntary new 'Economic Empowerment for the Disadvantaged' or 'EED' scorecard. On this basis, the number of medical scheme members would rise from 8.9 million to some 22 million;

5.4 Low-cost primary health insurance products should be retained, not barred. These, in return for risk-rated premiums ranging from R90 to R300 a month, would also entitle people to a minimum package of primary services. This insurance option would be even more affordable, while employers could again be asked to contribute two-thirds of the monthly premiums payable by their employees in return for a tax credit and voluntary EED points;

5.5 Gap insurance policies and hospital cash plans should be retained, without the restrictions now being introduced, and would safeguard people from major in-hospital expenses;

5.6 Risk-rated change-of-health status insurance policies should be made mandatory for all employees, who currently number some 15.5 million.[184] With a risk pool this size, premiums could be kept low (to some R100 a month), while compensation for insured risks would be paid into the HSAs of those affected, so helping to cover the cost of major out-of-hospital expenses;

> *State-funded health vouchers should be introduced for the 9 million South Africans who are unemployed and the 4 million people who currently receive old-age pension or disability grants. Costs would be met by minimising the fraud and inflated pricing which currently taints some 40% (R240bn) of the state's R600bn procurement spending. Some of the current public healthcare budget could also be redirected.*

5.7 State-funded health vouchers should be introduced for the 9 million South Africans who are unemployed (on the expanded definition) and the 4 million people who currently receive old-age pension or disability grants. (Children under 18 would generally be included in the UHC system via their parents and their medical scheme membership or health insurance cover.) These health vouchers would be redeemable solely for medical scheme membership and health insurance policies, including change-of-health status policies, as earlier outlined. Costs would be met by minimising the fraud and inflated pricing which currently taints some 40% (R240bn) of the state's R600bn procurement spending. In addition, some of the current public healthcare budget could be redirected into funding these health vouchers, as the cost pressures on the public sector would diminish with so many South Africans now able to obtain treatment in the private sphere;

5.8 State-funded health vouchers should also be made available to help pay the higher risk-rated premiums of those who are already old or ill when risk rating is restored. These vouchers could be funded in the same way, or by following Sweden's example and privatising urban public hospitals;

5.9 Poor management of public hospitals and clinics should be countered by shifting from damaging BEE and cadre deployment policies to a new system of 'economic empowerment for the disadvantaged' ('EED'). This would be far more effective in expanding opportunities for the great majority. It would also restore efficiency and accountability in management, thereby strengthening

internal discipline and ensuring compliance with key norms and standards;

5.10 Pending these reforms, public-private partnerships should be encouraged, with the administration of public hospitals and clinics outsourced to private firms, under parameters set by the state, and via an open and competitive tendering process;

5.11 The private training of doctors, nurses, specialists and other providers should be allowed, so as to increase supply and help meet increased demand. Regulatory restrictions on the establishment and expansion of private hospitals and clinics should be removed, while many more low-cost day hospitals should be introduced in both the public and private sectors. Innovative mechanisms to increase competition and hold down treatment costs should be encouraged;

5.12 The government should embark on structural policy reforms aimed at promoting investment, raising the growth rate to 6% of GDP, and generating millions more jobs.

5.13 As employment expands and earnings rise, South Africa should seek to introduce a Singapore-type of UHC, in which all employees must save for their health needs and contribute to a privately administered basic health insurance plan, which helps pay large hospital bills and costly out-patient treatments. South Africa should also adopt the four core ideas that underpin Singapore's UHC system: that people should take responsibility for their own health and avoid over-reliance on the state; that competition and market forces should be used to increase efficiency and reduce costs; that the government should intervene only where this is essential to help the poor; and that no health care service should be free at the point of delivery, as this encourages over-consumption.

Despite some points of difference, there are many commonalities in these alternative proposals. All agree that the most important requirement for a successful UHC system lies in giving the poor increased access to private health care. Such access should be financed by the government, either through state-funded vouchers or by some variant of these.

Despite some points of difference, there are many commonalities in these five alternative proposals. All agree that the most important requirement for a successful UHC system lies in giving the poor increased access to South Africa's effective system of private health care. Such access should be financed by the government (either through state-funded vouchers, as the IRR suggests, or by some variant of these). Affordability should be increased by allowing low-cost medical schemes and primary health insurance products, and by either returning to risk rating (the most cost-effective option for most people) or introducing risk equalisation between medical schemes. Medical scheme membership and/or health insurance cover should be mandatory for all employees, with premiums for lower-paid employees buttressed by employer contributions for which businesses should be able to garner tax credits (plus EED points, says the IRR). Once millions of South Africans are empowered in this way, medical schemes and health insurers will have to compete their custom, helping to encourage innovation and contain costs.

All five proposals also agree that the efficiency of public hospitals and clinics must be greatly increased. This requires merit-based appointments, strong internal discipline and accountability for performance, and effective action against corruption and inflated pricing. In the short term, it probably also requires sound public-private partnerships, with the administration of health facilities contracted out to private firms, within the parameters set by the state, through open and competitive tendering processes.

All five further agree that the supply of health facilities and health providers must be greatly increased. Again, reform must start with the removal of current regulatory constraints, so making it easier for the private sector to establish day hospitals and other health facilities. Private institutions could then also start training the doctors, nurses, specialists, and other providers the country so badly needs. In addition, every effort must be made to expand the reach of limited resources through increased efficiency and innovation.

All five also concur in recognising (explicitly or implicitly) that the government should focus on increasing the number of South Africans able to take care of their own health needs. As the IRR, in particular, has stressed, it must put the policy emphasis on promoting growth, rather than stepping up redistribution; on attracting investment, rather than threatening property rights; on increasing the quality of education, rather than trying to level it down to the lowest common denominator; and on stimulating the generation of millions of new jobs, rather than deterring employment via ever more onerous regulation.

The South African economy still has enormous strengths, compared to many other emerging markets. It does not have to trail far behind the rest of the world on annual growth and other key indicators. With the right policies in place in health and other spheres, the country could start achieving growth rates of 6% to 7% of GDP. Growth of this kind would see its economy double in every ten years or so and would be more effective than anything else in expanding opportunities and building prosperity.

Time for an affordable, constitutional, and workable alternative

South Africa needs a new system of UHC which is affordable, constitutional, and workable, but the NHI proposal meets none of these requirements.

That the NHI is unaffordable has been made crystal clear by Mr Gigaba's frank assessment of the looming debt and wider economic crisis confronting the country. In his medium-term budget policy statement (MTBPS) of 25th October 2017, the finance minister acknowledged that:[185]

- the growth rate is unlikely to exceed 0.7% of GDP in the current financial year and will remain below the population growth rate (1.7%) for yet another two years, though it could reach 1.9% in 2020;
- revenue collected in this tax year will be R51bn less than earlier projected;

> *That the NHI is unaffordable has been made crystal clear by Mr Gigaba's medium-term budget policy statement of 25th October 2017. Gross public debt is expected to rise to R3.4 trillion (60% of GDP) in 2020/21, even without the NHI. Interest payments are expected to increase to R223bn in 2020 and will then absorb 15% of tax revenues.*

- the anticipated budget deficit has been revised upwards to 4.3% of GDP (from the 3.1% projected in the *Budget Review* six months earlier);
- gross public debt is expected to reach R2.5 trillion by the end of this financial year and to rise to R3.4 trillion (60% of GDP) in 2020/21, even without the NHI;
- Interest payments are expected to rise to R223bn in 2020 and will then absorb 15% of tax revenues, or 15c in every R1 of revenue collected.

Already, interest payments on public debt cost the country no less than R550m a day.[186] If ratings agencies further downgrade South Africa's sovereign credit rating (which seems likely on the figures revealed in the MTBPS), debt-servicing costs will rise yet higher. Mr Gigaba's growth projections are also likely to prove overly optimistic, as the government has no credible plan to restore business confidence or attract more direct investment, either local or foreign. Growth is likely to remain at less than 1% of GDP and could even turn negative, depending on the extent to which property rights and business autonomy are further reduced under the rubric of 'radical economic transformation'

Against the economic data set out in the MTBPS, the 3.5% growth rate used by the White Paper to estimate the additional revenue needed to fund the NHI in 2025 is even more unrealistic. So too is the White Paper's projection of what the NHI will cost in that year. According to the MTBPS, public health spending, even without the NHI, will rise to R235bn in 2020.[187] This is only R21bn less than the R256bn the White Paper sees the NHI as costing when it becomes fully operational five years later. This further confirms that the White Paper's figures on the costing and financing of the NHI are entirely unrealistic.

It is not surprising, thus, that the MTBPS was largely silent on NHI implementation. Having noted that legislation to establish the NHI Fund was still being drafted, it added that the proposed scrapping of the medical scheme tax credit needs further thought. As earlier noted, Mr Gigaba now recognises that the tax credit is 'well-targeted to lower- and middle-income taxpayers' and that its removal could negatively affect '1.9 million taxpayers [with] a taxable income of less than R300 000'.[188]

Partly because it is so unaffordable, the NHI is also *unconstitutional*. The White Paper claims that the NHI is fully in keeping with the guarantee of access to health care in Section 27 of the Constitution, but this is not so. Section 27 says that 'everyone has the right to have access to health care services'. It thus obliges the state to 'take *reasonable* legislative and other measures, within its *available* resources, to achieve the progressive realisation of this right'.[189] However, far from bringing about increased access to health care, the NHI will deprive many South Africans of the access they currently enjoy. Introducing NHI is thus not a 'reasonable' measure for the state to take. It will also require a level of spending far in excess of the resources 'available' to the government – and is inconsistent with Section 27 for this reason too.

The NHI proposal also contradicts other guaranteed rights. Forced participation in the NHI Fund is inconsistent with the right to freedom of association in Section 18 of the Bill of Rights. Barring health care professionals from private practice – as all the state controls intrinsic to the NHI will do – is inconsistent with the right of every citizen 'freely…to choose their own profession' under Section 22 of the Bill of Rights.[190]

> *Far from bringing about increased access to health care, the NHI will deprive many South Africans of the access they currently enjoy. Introducing NHI is thus not a 'reasonable' measure for the state to take. It will also require a level of spending far in excess of the resources 'available' to the government. The NHI proposal is thus inconsistent with Section 27 of the Constitution.*

The regulatory or indirect expropriation of all private hospitals, private practices, and private medical schemes is also contrary to the Constitution, irrespective of what the Expropriation Bill might say. Though the property clause (Section 25) does not include a definition of 'expropriation', the term is generally understood as including both direct and indirect/regulatory takings. This broad meaning is also reflected in a host of bilateral investment treaties all around the world. Moreover, if the state could circumvent the Constitution simply by resorting to regulatory expropriations, this would destroy the 'proportionate balance' which the property clause (in the words of the Constitutional Court) is intended to secure.[191]

The NHI is *unworkable* too. By centralising control over health care in a corrupt and inefficient state, it will drive many health providers out of the country, reduce the supply of medicines and other essential goods and services (as unpaid suppliers will not keep supplying), and generate long waiting times for everyone. Instances of medical negligence are also likely to increase in thoroughly over-burdened facilities, which will confront a doubling in demand for health care but will lack the resources to meet this.

The real objectives behind the NHI are not to improve access to health care but rather to increase the power and control of the ruling ANC. Part of the aim is to push the private sector out of a key sphere and increase dependency on the state. This will also weaken the middle class, as many wealthier South Africans may choose to emigrate rather than be forced to rely on the inefficient health services that will remain. The more the middle class erodes, the more this will strengthen the ANC's hold on power, as middle-class voters are the ones most likely to shift to rival parties. Giving a greatly expanded army of bureaucrats ever more control over the pricing and provision of health care will also increase the ANC's powers of patronage, while generating many opportunities for individual enrichment too.

A critical part of the ANC's objective is, of course, to use the NHI to advance the national democratic revolution (NDR). Both the ANC and its communist allies have been committed to the NDR since the 1960s, for they see it as offering an incremental but 'direct' way to take South Africa from a predominantly capitalist

economy to a socialist and then communist one. Putting an end to private health care and vastly empowering the state will, of course, serve this ideological aim. But empowering the state in this way will also open up many opportunities for self-enrichment for a small political elite, who are becoming increasingly aware of how NDR goals can be harnessed to their own kleptocratic and selfish ends.

If South Africa is to attain the benefits of economic growth, rising employment and expanding prosperity, the ANC's outdated and damaging NDR ideology must be jettisoned. So long as the ruling party remains intent on pursuing a socialist and communist future, investment will be muted, growth limited, and unemployment high. This dismal situation is also precisely where South Africa now finds itself, as Mr Gigaba's medium term budget policy statement so graphically shows.

Putting an end to private health care and vastly empowering the state will, of course, serve ideological aims. But it will also open up many opportunities for self-enrichment for a small political elite, who are becoming increasingly aware of how NDR goals can be harnessed to their own kleptocratic and selfish ends.

However, even in its current straitened circumstances, the country could still implement a system of universal health coverage (UHC), which is based on the five proposals earlier outlined and which would be affordable, constitutional, and effective in meeting health needs. At the same time, if this initial UHC system is to expand and keep improving the benefits it offers to a growing population, unemployment must fall to 6% or less, the tax base must vastly expand, and the annual growth rate must rise to a minimum of 5% of GDP a year.

All these gains can yet be achieved. However, they will become increasingly unattainable if the ANC continues to propel the country down the NDR path. This outdated ideology – which even its Soviet authors have long abandoned – must simply be jettisoned, along with the NHI proposal it has helped to spawn.

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