South African Institute of Race Relations NPC (IRR)
Submission to the
Department of Health
regarding the
National Health Insurance Bill of 2018
and the
Medical Schemes Amendment Bill of 2018
Johannesburg, 21st September 2018

Contents **Page**

Introduction

The minister of health, Dr Aaron Motsoaledi (the minister), has invited interested persons to submit written comments on the National Health Insurance Bill of 2018 (the NHI Bill) and the Medical Schemes Amendment Bill (the MSA Bill) by 21st September 2018.

This submission on the NHI Bill and the MSA Bill is made by the South African Institute of Race Relations NPC (IRR), a non-profit organisation formed in 1929 to oppose racial discrimination and promote racial goodwill. Its current objects are to promote democracy, human rights, development, and reconciliation between the peoples of South Africa.

No proper public participation

Public participation in the legislative process is a vital aspect of South Africa's democracy, as the Constitutional Court has repeatedly reaffirmed in judgments spanning a decade or more. These include *Matatiele Municipality and others* v *President of the Republic of South Africa and others*, *Doctors for Life International* v *Speaker of the National Assembly and others*, and *Land Access Movement of South Africa and others* v *Chairperson of the National Council of Provinces and others.*[1]

The key constitutional provisions in this regard are Sections 59, 72, and 118. According to Section 59(1) of the Constitution, the National Assembly 'must facilitate public involvement in the legislative…processes of the Assembly and its committees'. In the *New Clicks* case in the Constitutional Court, Mr Justice Albie Sachs noted that there were many ways in which public participation could be facilitated. He added: 'What matters is that…a reasonable opportunity is offered to members of the public and all interested parties *to know about the issues* and to have an adequate say'. This passage was quoted with approval in both *Doctors for Life* and in the *Land Access* case.[2]

If people are to have a proper opportunity to 'know about the issues', they must be given adequate information about the likely costs and benefits of both the NHI Bill and the MSA measure. However, such information has not been provided. Instead, the public has been left in the dark as to:

- what health services the proposed NHI Fund will in fact cover, and how much this coverage (depending on budget constraints) will change from year to year;
- how the supply of health professionals and facilities will realistically be expanded to cater for the increase in demand the promise of 'free' health services is sure to trigger;
- what the NHI system is likely to cost, the 2010 estimate of R256bn in 2025 (on which the minister continues to rely) being eight years old and entirely unrealistic;
- how the country can afford the large sums likely to be needed for the NHI when the economic growth rate is so low, the unemployment rate is so high, and public debt (including government guarantees to struggling state-owned enterprises) already stands at a worrying 70% of GDP;

- just how big a bureaucracy will be needed to administer the NHI Fund and implement state price and other controls on every aspect of health care;
- whether the increased taxes needed to fund the NHI can realistically be imposed on a small and already over-burdened tax base;
- why the minister has ignored the Davis Tax Committee's warning that the NHI cannot be sustained without higher rates of economic growth;
- whether the NHI Fund can realistically be shielded from the gross inefficiency and rampant corruption which increasingly plagues Eskom and other state monopolies; and
- why medical schemes are to be regulated into bankruptcy under the MSA Bill when the NHI will clearly not be able to meet the country's health needs – and South Africans will still require an effective private sector alternative on which to rely.

Having been denied all this essential information, the public has been asked to comment on the bare bones of the NHI system and the MSA Bill without being equipped to 'know about the issues' and make informed inputs. This has turned the public participation process into a travesty of what the Constitution requires.

No satisfactory SEIAS assessment

Since September 2015, all new legislation in South Africa has had to be subjected to a 'socio-economic impact assessment' before it is adopted. This must be done in terms of the Guidelines for the Socio-Economic Impact Assessment System (SEIAS) developed by the Department of Planning, Monitoring, and Evaluation in May 2015. The aim of this new system is to ensure that 'the full costs of regulations and especially the impact on the economy' are fully understood before new rules are introduced.[3]

According to the May 2015 Guidelines (the Guidelines), SEIAS is also intended to ensure that 'government policies do more to support [four] core national priorities'. These are 'social cohesion, economic inclusion, economic growth, and environmental sustainability'. The Guidelines state: 'A common risk is that policy/law makers focus on achieving one priority without assessing the impact on other national ones.' What is needed, however, is for 'a balance to be struck between protecting the vulnerable and supporting a growing economy that will ultimately provide them with more opportunities'.[4]

The Guidelines expressly deal with proposed new legislation that aims to 'achieve a more equitable and inclusive society', but which 'inevitably imposes some burdens on those who benefited from the pre-existing laws and structures'. The document notes that 'relatively small sacrifices on the part [of past beneficiaries] can lead to a significant improvement in the conditions of the majority'. However, it adds, 'the challenge is to identify when the burdens of change loom so large that they could lead to excessive costs to society, for instance through disinvestment by business or a loss of skills to emigration'.[5] It is precisely such 'excessive costs' (of major disinvestment and migration) that could easily be triggered by both the NHI Bill and the MSA Bill.

According to the Guidelines, SEIAS must be applied at various stages in the policy process. Once new legislation has been proposed, 'an initial assessment' must be conducted to identify different 'options for addressing the problem' and making 'a rough evaluation' of their respective costs and benefits. Thereafter, 'appropriate consultation' is needed, along with 'a continual review of the impact assessment as the proposals evolve'.[6]

A 'final impact assessment' must then be developed that 'provides a detailed evaluation of the likely effects of the [proposed law] in terms of implementation and compliance costs as well as the anticipated outcome'. When a bill is published 'for public comment and consultation with stakeholders', this final assessment must be attached to it. Both the bill and the final assessment must then be revised as required, based on the comments obtained from the public and other stakeholders. Thereafter, when the relevant bill is submitted for approval to the Cabinet, the final assessment, as thus amended, must be attached to it.[7]

However, no SEIAS assessment of either the NHI Bill or the MSA Bill has been carried out and made public. A 'final impact assessment' of the NHI White Paper was conducted in May 2017, but no SEIAS assessment of the NHI Bill itself has been carried out. In addition, the 2017 SEIAS analysis of the earlier White Paper is too superficial to have any value.[8]

Far from providing a realistic assessment of the likely costs and benefits of the NHI system, the SEIAS report in 2017 simply echoes the minister's optimistic assumptions about the benefits the NHI will bring. It presumes that these benefits will in fact be achieved, while brushing over the likely costs of the NHI. It also ignores the key question of whether South Africa can afford or sustain the NHI when economic growth is so low, the relevant tax base is so small, and public debt is already so high and is still rising rapidly. In the face of all these salient factors, it is astonishing that the SEIAS report confidently asserts that no additional research into the costs, benefits, or risks of the NHI proposal is required.[9]

The 2017 SEIAS report also fails to provide any convincing reasons for rejecting the view – strongly expressed by business associations and industry stakeholders – that medical schemes should be allowed to 'supplement' the cover available from the NHI. Instead, the report unthinkingly accepts that these schemes should indeed be confined to covering health services that 'complement' those available via the NHI Fund. [10] To help the public understand the ramifications of this limitation on medical schemes, the SEIAS report should at least have set out its likely costs and consequences. It should also have given proper reasons for rejecting the merited concerns of business and other stakeholders, rather than dismissing them out of hand.

No SEIAS assessment of the MSA Bill has been made available to help deepen public understanding of this measure. In these circumstances, it is premature for the minister to bring the MSA Bill before Parliament. Instead, as the Guidelines require, a preliminary assessment should first have been made, which should have set out different options and their respective pros and cons. This report should then have been followed by a final assessment

with a 'detailed evaluation' of the bill's likely effects, compliance costs, and anticipated outcomes. This final evaluation should have been attached to the MSA Bill when it was published for comment. That none of this information has been made available makes it all the more difficult for the public to 'know about' the important issues raised by the measure. Again, the effect is to undermine the public consultation process on the MSA Bill and turn this into a travesty of what the Constitution requires.

The NHI Bill

The NHI Bill seeks to establish the NHI Fund, along with the various other entities needed for NHI implementation. However, like the June 2017 White Paper on which it is based,[11] the NHI Bill fails to deal with a host of vital issues.

Because the NHI Bill is so lacking in essential information, there is little to be gained from a detailed evaluation of its specific provisions. Instead, the entire NHI Bill needs to be withdrawn until all the missing – and essential – information about benefits, costs, affordability, efficiency, and effective mechanisms against fraud, corruption, and other potential abuses has been provided. In this process, the profound flaws in the current NHI proposal must also be addressed and convincingly overcome.

No remedy for public sector inefficiency

South Africa currently spends 4% of gross domestic product (GDP) on public health care, which is more than many other emerging economies can manage. But, despite the best efforts of many dedicated professionals working in the sector, the country gets little 'bang' for its substantial 'buck'. Instead, public health care is plagued by poor management, gross inefficiency, persistent wastefulness, and often corrupt spending.[12]

The upshot is that at least 85% of public clinics and hospitals cannot comply with basic health-care norms and standards, even on such essentials as hygiene and the availability of medicines. Cases of medical negligence – often involving botched operations or brain damage to newborn infants – have increased to the point where claims for compensation total R56bn. This is more than a quarter (27%) of the entire R201bn budget for public health care in 2018/19.[13]

The NHI makes no attempt to remedy these defects. Instead, it seems to assume that throwing more resources at the public sector will provide a cure-all, whereas poor skills, cadre deployment, and a crippling lack of accountability lie at the heart of the malaise. These are the key problems which need to be overcome, but the NHI Bill is likely to make them even worse by concentrating still more power in the hands of unaccountable officials.

A vast additional bureaucracy

The NHI will require a vast bureaucracy. This will start with the NHI Fund, into which all health monies will be placed and from which all health expenses will be paid. The NHI Fund will also have 'sub-units' to decide on NHI benefits, approve treatment protocols, set prices, accredit health providers, procure medicines and other supplies, pay for all goods and

services purchased, monitor the overall performance of the system, and guard against corruption and fraud.[14]

Many other bureaucratic entities will also be needed. These include an NHI Commission to oversee the NHI Fund, a National Health Commission to deal with non-communicable 'lifestyle' diseases, and a host of other committees to decide on treatment protocols, approve health products, oversee some 3 900 public hospitals and clinics, and maintain a data base with the details of all health providers and roughly 58 million patients.[15]

The Office of Health Standards Compliance (OHSC), which must assess whether health professionals and facilities qualify to participate in the NHI, will also need many more inspectors. To begin with, it will have to assess all public health facilities, which currently number close on 3 900. In addition, it will have to measure the performance of at least 31 000 private practices, which might also want to take part in the NHI. Both public and private facilities will also have to be re-assessed every five years, according to the NHI Bill, as OHSC certifications will not last longer than this period. This means the OHSC will need to review some 6 980 facilities in every year. This is almost ten times the 696 facilities it managed to assess in the 2016/17 financial year, as further outlined below.[16]

The NHI Bill makes no attempt to quantify the overall costs of this enormous bureaucracy. The White Paper's estimate that the NHI will cost R256bn in 2025 (its first year of full operation) also overlooks these expenses.[17] Yet all these new administrative entities will have to be suitably staffed, remunerated, equipped, and provided with appropriate office or other working space.

Unsustainably high costs

The NHI Bill is silent on the system's likely costs. As earlier noted, the 2017 White Paper puts the NHI's costs at its start in 2025 at R256bn (in 2010 prices), but this figure is outdated and has never been convincing. According to Dr Motsoaledi, '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'.[18] That, however, is precisely the point. South Africa cannot 'dream up' new revenue sources, especially with the economy having entered into recession, the unemployment rate at close to 30%, public debt standing at 55% of GDP, and interest payments on that debt already amounting to R180bn a year.[19]

When Dr Motsoaledi released the NHI and MSA Bills in June 2018, he once again shrugged off the vital issue of what the system is likely to cost. The amount in question was impossible to calculate, he said – and it was 'the job of the Treasury and Cabinet and the Government, not the minister' to provide the necessary funding for the NHI.[20] This fudging of the crucial cost issue is simply not good enough.

Since the NHI is intended to pool both public and private spending on health care, a realistic estimate of likely NHI costs can be devised by starting with the total of such expenditure in the current financial year. This is likely to come in at R446bn, according to the 2017 White

Paper. If we assume that health care spending will rise by 6% a year between now and 2025, then the NHI will cost R670bn in that year. Its costs will then rise further to roughly R900bn in 2030, R1 200bn in 2035, and R1 600bn in 2040.[21]

However, health inflation has in fact been higher than 6% for some time. In nominal terms, expenditure on public health care has been going up by roughly 8% a year on average. Spending on private health care has been increasing by much the same proportion, again as the official statistics cited in the White Paper show.[22]

If health spending keeps rising by 8% a year, NHI costs are likely to begin at 765bn in 2025. This is roughly 14% of projected GDP in that year. It is also not that far off the minister's earlier comment that NHI costs at the start could be as high as R1 trillion.[23] If R765bn is indeed the starting amount, NHI costs would thereafter rise to R1 120bn in 2030, to R1 650bn in 2035, and to some R2 425bn in 2040. This last amount would be roughly 30% of likely GDP, assuming the economy manages to notch up modest growth levels in every year. Public spending of this magnitude on health care within a scant 15 years of the system's introduction is completely unaffordable.

In addition, the NHI Bill, like the White Paper before it, offers no meaningful way of bringing down health-care costs. The NHI Bill reflects the White Paper's assumption that the NHI Fund will significantly reduce health-care costs by introducing 'a single-payer and single-purchaser fund', which will 'leverage its monopsony power' to 'strategically' purchase services and achieve major 'economies of scale'.[24] (A monopsony arises where one buyer interacts with many would-be sellers and thus has considerable market power.)

However, monopsony power will clearly have less impact in practice than the government's proposed price controls. Like the White Paper before it, the NHI Bill seeks to give the NHI Fund control over all health-care prices: from the costs of aspirin and rubber gloves to the fees payable to surgeons and GPs. The NHI Bill also echoes both the White Paper and the 2017 SEIAS report [25] in assuming that these price controls will be effective in cutting costs while enhancing quality. However, the more likely outcome is that many valuable therapies, health technologies, and diagnostic tests will be ruled out as too costly.

In addition, without a market mechanism to help determine needs, officials will have to decide what health services and products are likely to be required at different times and in different places. Since officials will be unable accurately to predict the health needs of some 58 million people, they will inevitably over-estimate some needs and under-estimate others. This in itself will make for major inefficiency. Bureaucratic control will also stifle innovation and promote corruption, adding to overall costs.

Moreover, 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.[26] This fundamental weakness in

the notion that a single purchaser will succeed in driving down health-care costs needs to be acknowledged, not brushed aside.

NHI financing

The NHI Bill also brushes over the key question of how the new system is to be financed. The White Paper on which the Bill is founded assumes that only R72bn in additional revenue will be needed to fund the NHI at its start in 2025. It then claims that this sum can be raised through a 4% surcharge on taxable income, a one percentage point increase in the VAT rate, a new payroll levy, or some combination of these additional taxes.[27]

However, the actual costs of the NHI are likely to be far higher than the White Paper's estimate. This means that the tax increases required will be much larger too. Yet the 2017 SEIAS assessment simply endorses the White Paper's flawed figures, accepting them at face value rather than questioning their validity. In addition, the VAT rate has already been increased by 1 percentage point (from 14% to 15%) with effect from April 2018, while the top marginal rate of personal income tax has already been hiked by 4 percentage points (from 41% to 45%). Hence, two of the tax increases which the White Paper and the SEIAS assessment earlier assumed could be dedicated to funding the NHI are already being used to help pay for government spending in general.[28]

The tax increases already introduced have also curtailed whatever space there might earlier have been to increase the tax burden even more. This is an important consideration, given the narrowness of the country's tax base. Some 19 million individuals were, of course, registered for personal income tax in 2016 (the latest year for which these figures are available), but most had earnings below the tax payment threshold. Hence, only 4.8 million out of the 19 million were in fact assessed for tax in that year. In addition, some 64% of all the personal income tax that was paid in 2016 came from roughly 600 000 people with annual taxable incomes of R500 000 or more.[29]

Much of the country's tax burden thus rests of this small group of individual taxpayers. Moreover, if increased taxes and reduced health services under the NHI were to encourage half of these individuals to emigrate, the personal income tax that could be collected would be reduced by roughly a quarter. This would make it far harder for the government to sustain its spending on the public sector wage bill, social grants, infrastructure, and a host of other needs.

In addition, the fiscus already faces a revenue shortfall of R50bn in the current financial year, as finance minster Nhlanhla Nene has pointed out. South Africa's public debt has also been rising very rapidly since 2008, when it stood at R630bn or 26% of GDP. Even without the NHI, public debt is now projected to rise to R2.7 trillion (55% of GDP) in the current financial year, and to reach R3.2 trillion (56% of GDP) in 2020. If government guarantees for the debts of Eskom and other state-owned enterprises are factored in as well, then overall public debt already stands at some 70% of GDP.[30]

The government's inability to contain rapidly rising public debt has already prompted two international ratings agencies to downgrade South Africa's sovereign debt to sub-investment or junk status. If public debt cannot convincingly be controlled, further ratings downgrades are sure to follow. This will harm the economy and greatly increase the government's interest bill, which already amounts to R180bn (almost as much as the public health care budget) in the current financial year.[31]

Relevant too is a warning by the Davis Tax Committee that the NHI system is unlikely to be 'sustainable'. Having made a careful examination of how the NHI could best be funded, the committee reported in March 2017 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] other laudable programmes', such as increased funding for post-school education or 'social security reform'.[32]

The May 2017 SEIAS assessment should have taken these salient warnings by the Davis Tax Committee into account. That the SEIAS analysis simply ignores them underscores once again the fundamental flaws in its analysis of the NHI.

The health care services to be provided

The NHI Bill is largely silent on the benefits the system will provide, saying these will be decided by the proposed 'Benefits Advisory Committee' in the light of the 'the potential funds' available.[33]

According to the June 2017 White Paper, the NHI is to cover cardiology, dermatology, neurology, oncology, psychiatry, obstetrics, gynaecology, paediatrics, orthopaedics, and surgery, including organ transplants of various kinds. At the primary health care level, it will provide '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 covered.[34]

This is an impressive list. In practice, however, the government will not have the R765bn that will probably be needed, in 2025 alone, to provide all these services to some 58 million South Africans. Demand is also likely to increase very strongly once all South Africans have been given the right to 'free' health services at all public and private facilities. People will flock in their millions to hospitals, specialists, doctors, and other providers for the treatment supposedly on offer through the NHI. Soon, however, they will find that there are not nearly enough resources available to meet the scale of need.

What the NHI provides in practice will thus be very much less than what the White Paper has promised. This outcome is evident even in wealthy Canada, where waiting times for treatment have gone up substantially since the introduction of a single-payer system similar

to the NHI. In Canada, waiting times to see a specialist and then be treated have more than doubled from 9.3 weeks in 1993 to 21 weeks in 2017.[35] Yet Canada's health system is far better resourced than South Africa's, while Canadians also have the choice of crossing into the US to seek treatment there. Many take advantage of this option, thereby reducing the pressure on the Canadian system in ways that will not be available here.

Also relevant is a 2015 World Bank study of 24 developing countries, all of which had promised universal health coverage but none of which were in fact able to deliver this. In each country, said the Bank, there was a significant 'gap between the free comprehensive benefit package promised...and the de facto actual benefits'.[36] South Africa, with its massive unemployment and limited resources, is unlikely to do any better than these other states in providing comprehensive services.

Fraud and corruption

The enormous pot of revenue that will be gathered together in the NHI Fund is likely to become a magnet for corruption, especially in procurement. Already, in the words of Kenneth Brown, a former chief of procurement at the National Treasury, between 30% and 40% of the government's procurement budget (worth R600bn at the time) is tainted by 'inflated pricing and fraud'.[37] When the NHI Fund takes charge of all the tenders required to meet the health needs of some 58 million people, it will provide many more opportunities for 'tenderpreneurs' to feather their own nests. Unless such abuses can effectively be countered, the hundreds of billions of rands in the annual procurement budget of the NHI Fund are likely to be equally compromised by corruption.

Many fraudulent medical claims may also be submitted to the NHI Fund. Already, the lodging of fraudulent claims against medical schemes is 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%'.[38] Under the NHI, South Africa could lose even larger sums to fraudulent claims unless effective steps are taken to prevent this. Again, however, the NHI Bill provides no practical mechanisms to counter such abuses.

The SEIAS assessment acknowledges that there is a 'high' risk of fraud and corruption in the NHI system. However, it then brushes the problem aside, claiming that this risk will be countered by the 'transparent appointment of appropriately qualified personnel to staff the NHI Fund' and the use of other mitigation strategies.[39] These empty assurances are again unconvincing.

Major inefficiencies 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.[40]

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 Democratic Alliance (DA) commented that 'these figures were astronomical and could easily result in small medical practices having to shut their doors'.[41]

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, including some 94 000 claims which had already been approved for payment by the Medical Bureau for Occupational Diseases.[42]

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.[43]

The gross inefficiencies at the Compensation Fund, the Commission, and the RAF provide some indication of the problems likely to arise under the NHI. However, the inefficiencies at the NHI are likely to loom far larger, as the NHI Fund will, at minimum, have a budget of R256bn a year (the figure provided in the White Paper). This is very much larger than the R11bn annual budget of the Compensation Fund and the R36bn with which the RAF deals each year. In addition, instead of having to cater for only small groups of South Africans, the NHI Fund will have to pay for all the health services provided by all accredited hospitals, clinics, doctors, specialists, nurses, and other health professionals to some 58 million South Africans.

According to the NHI Bill, payments to health professionals at levels about the primary one will generally be channelled through central, provincial, and district hospitals, which in turn will be responsible for paying the relevant health care providers. In much the same way, payments to health care professionals at the primary level will generally be made via the proposed 'Contracting Units for Primary Health Care', which will receive bulk sums from the NHI Fund and then disburse these further. [44]

These arrangements for bulk payments will help reduce the number of claims from health care professionals needing to be handled by the NHI Fund itself. The overall payment burden will nevertheless be considerable. In addition, the NHI Bill stresses that the payments made

to health professionals must be based on 'the quality and value of the services' they have provided.[45] Health professionals may thus have to wait for long periods while NHI bureaucrats assess the 'quality' and 'value' of their services against criteria which remain unclear.

The NHI Fund will also be responsible for paying a host of other bills. As the 'strategic purchaser' within the new system, it will be solely responsible, among other things, for procuring all the medicines, medical devices, diagnostic tests, consumables, and other health goods and services that may be needed by 58 million South Africans in any given year.[46]

The three compensation funds earlier described have dismally failed to deal effectively with a far smaller number of claims for reimbursement. 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 procurement contracts and a plethora of other financial arrangements in every 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 certification 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 health-care 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 fully 'compliant' with these norms. 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'.[47]

Compliance standards have generally deteriorated since then, and especially so at the primary level which will be crucial to the NHI. Between 2012 and 2016, compliance among the clinics and community health centres assessed by the OHSC 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 notched up compliance scores above 50%, in 2016 only Gauteng came in above the 50% level with a score of 55% (down from 69% in 2012).[48]

In the 2016/17 fiscal year, the OHSC inspected 696 public health-care facilities. It found that only five of them were fully compliant, as they had scores of 80% and above. On cleanliness, the prevention of infections, and the availability of medicines, scores in most provinces were

generally below 50% – though some facilities in Gauteng, KwaZulu-Natal, and the Western Cape did significantly better. [49]

Summing up its 2016/17 findings, the OHSC report said that 'leadership and management, including operational management, was poor or lacking'. In addition, the health establishments found to be non-compliant in specific spheres showed 'a lack of competence', as well as 'inadequate supportive supervision'. Overall, there had been little or no improvement in the overall scores awarded to seven provinces. In addition, where the OHSC had conducted repeat inspections of facilities initially scoring below 50%, it had found that many of the hospitals, clinics and community health centres in question had 'deteriorated over time'.[50]

This OHSC report once again suggests that few public facilities will qualify to take part in the NHI. This will greatly diminish the health care resources available to 58 million South Africans, just as demand for health services goes sharply up. In addition, the NHI Bill makes it clear that health professionals will have to be in possession of 'certificates of need' before they can qualify for NHI accreditation. (The National Health Act 2003 provides for such certificates, under provisions that have yet to take effect but which are clearly to be made operative before the NHI Bill commences.) These certificates will most likely be granted to private practitioners who are currently based in well-resourced towns and suburbs only if they move from their established practices to under-serviced areas. However, if doctors are called upon to uproot themselves in this way, many might decide that they would rather leave the country altogether – as the South African Private Practitioners' Forum and various others have recently warned.[51]

South Africa is already gravely short of nurses, doctors, specialists, and other health providers, yet the NHI Bill offers no credible means of increasing their supply. On the contrary, the pool of available health providers and facilities is likely to shrink substantially once the NHI takes effect. In a nutshell, this is firstly because a scant 15% of public clinics and public hospitals currently comply sufficiently with OHSC norms and standards to qualify for NHI participation. In addition, many private specialists, doctors, and other health providers with scarce skills are likely to emigrate, rather than subject themselves to NHI controls over where they may practise, what fees they may charge, what treatment protocols they must follow, and what diagnostic tests, medicines, medical devices, and healthcare technologies they are permitted to use.

Many unmet promises

The NHI is unlikely to succeed in providing the full range of health services identified in the White Paper. As earlier noted, these range from cardiology to oncology and organ transplants of various kinds, along with a host of primary services. The NHI may well promise all these services, but in practice it will lack the human and financial resources needed to provide them all. It may also cover fewer and fewer health services in each succeeding year, as 'budget caps' are to be used (as the SEIAS report stresses) to 'ensure that overall expenditure does not exceed available resources'.[52]

Unless economic growth increases substantially, the country's tax revenues are unlikely to keep pace with expanding demands in health and other spheres. With health inflation averaging 8% a year and budget caps in place to ensure NHI spending does not exceed the revenue available, the health services covered by the NHI at the start may in time have to be significantly reduced.

However, by the time people realise that the NHI cannot deliver on its golden promises, the private health care system will effectively have been destroyed. South Africans will then be left with nothing but a failing state monopoly on which to rely.

The Medical Schemes Amendment Bill of 2108

The probable impact of the MSA Bill is best assessed in the light of the ANC's long-standing vendetta against the private system – and the many regulatory interventions it has already introduced to hobble private health care.

The ANC's vendetta against private health care

The main purpose of the NHI is not to improve health services but rather to drive the private sector out of the health-care sphere. The NHI proposal is intended to help achieve this by putting an end to the medical schemes that fund the bulk of private health care and are essential to its survival.

Putting an end to 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 2018/19 financial year, spending on private health care is expected to amount to R230bn, of which 83% (R192bn) will go to medical schemes, R31bn to out-of-pocket purchases, and R5bn to health insurance. South Africa's 82 medical schemes are thus vital in providing access to private health care. [53]

The number of people belonging to medical schemes has risen from 6.9 million in 1997 to 8.9m in 2016. However, because the population has also increased, medical scheme membership as a proportion of the total has remained much the same, at roughly 16%. The demographic representation of medical schemes members has nevertheless changed substantially, for 49% of members are now black, while 10% are so-called 'coloureds', 7% are Indian and the remaining 34% are white.[54]

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 mandatory pre-payments towards the NHI'.[55] This financial obligation in itself could bring about the demise of many medical schemes, as most people will battle to afford both their medical aid contributions and the additional taxes required to fund the NHI.

Medical schemes will also, as the NHI Bill makes clear, be confined to offering 'complementary' cover, so as to fill in any gaps in the benefits provided by the NHI. Restricting medical schemes in this way is likely to sound their death knell. A 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. Monthly contributions would thus have to be set so high that only the very rich could afford them. Few medical schemes will survive this double regulatory whammy.[56]

The minister remains adamant that all medical schemes will 'eventually be gone', once the NHI is fully 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', in the form of the NHI Fund.[57]

In the interim, the government has been moving towards this outcome by pushing up the costs of medical scheme membership and refusing to allow low-cost options.

Making private health care more costly to access

Over the past decade, government regulations have helped to push up the costs of medical scheme membership and to exclude more affordable means of accessing private sector care. The government has thus:[58]

- introduced an arbitrary reserve requirement (25% of annual contributions) which is unnecessarily high for many medical schemes;
- insisted on open enrolment and community rating, which makes it harder for schemes to hold down costs by attracting the young and healthy;
- insisted that all medical schemes 'pay in full' for some 300 'prescribed minimum benefits' (PMBs), irrespective of whether members want this cover or not;
- reduced the tax benefits which help make medical scheme membership more affordable, and vowed to eliminate these altogether over time;
- resolved to end the government subsidy which helps public servants pay their medical scheme contributions; and
- barred the introduction of low-cost medical schemes, which (having been spared the PMB obligation) could have made membership available to a further 15 million people at premiums averaging R200 a month per person.

Key provisions in the MSA Bill

The MSA Bill will tighten the regulatory stranglehold on medical schemes still further. Since most people do not realise how state interventions have already pushed up the costs of belonging to medical schemes, many will doubtless welcome the MSA Bill's apparent aim to made medical aid more affordable. However, any gains are likely to prove short-lived – for the MSA Bill could soon push many medical schemes into bankruptcy.

The key proposed changes are as follows:

- medical schemes will no longer be allowed to offer different benefit options and will instead have to cover a single, comprehensive package of primary and other health services, as decided by the government (which will replace the current PMBs);[59]
- medical schemes will have to 'pay in full' for this package of health services and will be barred from seeking co-payments from their members;[60]
- contributions for mandatory benefits will be based on income, rather than health status, and the better off will have to pay significantly more to subsidise the poor;[61]
- open medical schemes will have to admit all those who apply to join, without regard to their health status (though people who have not belonged to medical schemes in the past 90 days will have to wait three months before they can access their benefits);[62]
- medical schemes will be able to terminate the membership of those who fail to pay their contributions, but will have to take back these non-paying members if they re-apply for admission;[63] while
- the only penalty medical schemes will be able to impose on those who fail to pay and then apply to rejoin is an 'administrative penalty', equal (it seems) to one month's contribution.[64]

Says Dr Motsoaledi: 'The essence of NHI, which must start now, even within the present medical aid schemes, is that the rich must subsidise the poor, the young must subsidise the old, and the healthy must subsidise the sick.'[65]

The proposed rules will encourage many low-income households to join 'open' medical schemes (those available to everyone and not restricted to company employees, for instance). The monthly contributions of these new members will be low, in line with their incomes. Higher-income households will have to pay substantially more to subsidise these new entrants, but may be unhappy with the sole package of benefits now available to them. This could encourage high-paying members to withdraw. Medical schemes will then have larger and larger numbers of low-paying members, with few high-paying ones to help bear the financial burden.

Medical schemes will have to pay in full for all the health services accessed by this larger pool of low-paying members. People who anticipate a major health event – an operation, or the birth of a baby, for example – will have incentives to join schemes four months in advance (given the three-month waiting period), pay premiums for five months, say, and then exit once again. This will put medical schemes under even more financial pressure.

In addition, people may soon realise that they cannot be refused re-admission if their membership is terminated for a failure to pay contributions. They will have to pay administrative fines on re-admission, but for low-income families with small monthly contributions, this would not be much of a disincentive. Medical schemes may then find themselves with large numbers of members who, in practice, barely pay any contributions at all, yet are entitled to comprehensive health services that schemes must pay for in full. This will put even more pressure on their sustainability.

Many people who now find it hard to afford medical scheme membership – and who resent the co-payments they often have to make – are likely to welcome these regulations. They will also benefit substantially from them for a period, as the benefits they receive will far outweigh the contributions they have to make. In the longer term, however, medical schemes will find it increasingly difficult to survive. That in turn will leave South Africans with little option but to rely on the NHI, irrespective of how inefficient it proves.

The MSA Bill will also add to the financial pressure on medical schemes by prohibiting them from covering any health services that are also covered by the NHI Fund. Since 2015 the government has clearly been intent on confining medical schemes to covering health services that are 'complementary' to those offered by the NHI. The MSA Bill now seeks to write that intention into law. It thus empowers the Registrar to 'restrict the extent of the benefits offered by medical schemes' so as to 'eliminate duplicative costs' for benefits covered by the NHI Fund.[66]

Though this wording might perhaps seem ambiguous, the minister's intention is spelt out further in the NHI Bill of 2018. This confines the users of the NHI Fund to the purchase of 'complementary health service benefits that are not covered by the Fund'. This restriction goes even further than the White Paper earlier envisaged, for it bars people from buying health services already covered by the Fund not only through their medical schemes, but even via their own out-of-pocket payments.[67]

Medical schemes will thus know, well before the NHI comes into operation, that their sustainability will be further reduced once this occurs. This may more readily persuade those which are struggling under the regulatory burden to seek to join up with bigger schemes. This will facilitate the 'consolidation' of medical schemes which Dr Motsoaledi is intent on bringing about. Smaller schemes with fewer than 6 000 members (the minimum number laid down in current regulations under the Medical Schemes Act of 1998) are likely to be the first to succumb. The more this consolidation process takes place, the fewer choices South Africans will have. By the time the NHI takes effect, thus, most medical schemes may already have disappeared. This will reduce resistance to the NHI, as people will have few other options on which to rely.[68]

Ramifications of the NHI and MSA Bills

The government claims that the NHI system will successfully provide quality health care that is free at the point of delivery to all South Africans, irrespective of their income. It also claims that the new system will reduce rising health care costs by harnessing the monopsony purchasing power of a single purchaser – the proposed NHI Fund – and empowering the state to fix the prices of all health care goods and services.

Implicitly, the government is promising that 58 million South Africans will soon be able to access the country's world-class private health-care sector through a state-controlled system. It implies that this can be adequately funded through the mandatory pre-payments of the relatively few taxpayers who have the capacity to contribute significantly to the new system.

It also suggests that this additional revenue, coupled with the additional resources the private health care sector can supply, will greatly reduce the pressure on the public health care system and so increase its efficiency.

In practice, however, the beguiling promise of the NHI proposal will prove false. Instead, the NHI will leave tens of millions of South Africans in the lurch. They will have little or no say as to the doctors, specialists, or other health care professionals they are able to consult. They will be barred from the treatments and medicines they require if bureaucrats decide that these essentials are too costly. This problem will also worsen every time the rand depreciates – an outcome which the introduction of an unaffordable NHI is likely to speed up.

People will find themselves deprived of choice and entirely dependent on a state monopoly. Under the NHI, it is the government alone which will decide on all aspects of health care – from the health care services to be covered to the fees to be paid to doctors and other providers, the medicines to be prescribed, the blood tests to be allowed, the medical equipment to be used, the new health technologies to be permitted, and the prices to be paid for every item, from aspirins and ARVs to sutures and cat scanners.

The government claims that these pervasive state controls will be effective in cutting costs and enhancing quality. But the huge bureaucracy needed to implement them will be enormously costly in itself. Pervasive regulation will also stifle innovation, reduce efficiency, and promote corruption.

In addition, the country's 82 medical schemes, which are crucial to the survival of the private health care system, will be pushed out of operation over time. As earlier noted, the minister is adamant that all medical schemes will 'eventually be gone', once the NHI is fully in operation. The 82 open and closed schemes that currently provide people with many benefit options and a large degree of choice will 'all be collapsed into a single state-run medical aid plan': ie, the NHI Fund.

The country's outstanding private health-care system will effectively be nationalised, giving the government a monopoly over health care. This is likely to be just as inefficient and vulnerable to corruption and 'capture' by a small political elite as the state's monopoly over electricity (via Eskom) has proved.

The NHI's beguiling promises will thus prove false. Steep tax increases will have to be introduced to fund the system, but the NHI will still lack essential financial and human resources. People will thus wait weeks, months, and even years for treatment. They will seldom get speedy help when they need it most: when children fall ill, or breadwinners are injured, or babies need to be delivered, or the elderly have strokes, or the chronically ill require their monthly medication. The treatment choices which currently exist will be removed – and people will find that they have no option but to rely on the state's single medical aid, irrespective of how badly it works.

The real reason for the NHI proposal

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'.

Behind this constant denigration of private health care lies the ANC's commitment to the national democratic revolution (NDR): a strategy developed by the Soviet Union in the 1950s to take former colonies from capitalism to socialism and then communism. In 1969 the ANC endorsed Moscow's idea that South Africa was 'a colony of a special type' (in which whites were the colonial oppressors and blacks their exploited subjects) and embraced the NDR. Though some 50 years have passed since then, the ANC regularly recommits itself to the NDR – as it did once again at its Nasrec national conference in December 2017.[69]

The real aim of the NHI is to help advance the NDR by;

- dislodging business from a key sphere of market-based provision,
- effectively nationalising private health-care resources,
- building dependency on the state, and
- establishing the principle that private spending must be pooled with public revenues for the benefit of those in need and in the interests of social solidarity.

This last objective is particularly important. Once the NHI precedent has been established, its example may in time be used to extend the 'pooling' principle to other spheres, including pensions – where proposals for a government-controlled 'national social security fund' are already being put forward. [70]

Dr Motsoaledi is thus determined to press on with the NHI, which he rightly identifies as 'the equivalent of "the land question" in health'.[71] However, there is no need for expropriation without compensation (EWC) in the health sector when incremental reforms would greatly improve the universal health coverage already available to all South Africans.

Alternatives to the NHI proposal

In recent years, 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

As the minister has repeatedly pointed out, 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 have access to 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'.[72]

The WHO's recommendations regarding UHC are, however, more tentative than Dr Motsoaledi is 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, work forces, and tax bases on which to draw.

In addition, 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. But 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*'.[73] 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 health-care system, while giving all South Africans access to its benefits. A new UHC system must also aim to improve efficiency within the public health-care sector, while ensuring that the country gets much more bang for its already extensive health-care 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.

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 and was more willing to embrace practical alternatives.

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.[74] 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 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 reclaim 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 contain 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.

Paul Harris/Julia Price Proposal (Option 2)

Paul Harris, a former CEO of Rand Merchant Bank and later a member of the High Level Panel of Parliament, together with his associate Julia Price, have put forward similar, albeit less detailed, proposals in their discussion paper for the High Level Panel. They suggest:[75]

2.1 Private medical schemes should remain in place, as should the Government Employees Medical Scheme (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';[76]

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.

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. Though the DA concept is sometimes poorly worded (making it difficult to understand), but its most important elements are as follows:[77]

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)[78] 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.

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'.[79] The FMF adds:[80]

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,... while the private sector provides up to 80% of health care in many developing countries';[81]

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 health-care 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 re-organisation' the White Paper says the NHI will require – this could have far-reaching consequences that are 'drastic and disastrous'.

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 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.[82] 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;

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 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 for 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 should also be allowed to train 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, building prosperity, and steadily increasing the range of health care options that people can afford.

However, if such a 'new dawn' is to be achieved, 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 will be limited or negative, and unemployment will persist at stubbornly high levels. This dismal situation is also precisely where South Africa now finds itself, with the economy having contracted by 2.6% in the first quarter of 2018 and by a further 0.7% in the second quarter of the year.

Unconstitutionality of the NHI

Section 27 of the Constitution says that 'everyone has the right to have access to health care services, including reproductive health care'. It also obliges the state to 'take reasonable legislative and other measures, within its available resources, to achieve the progressive realisation of this right'.[83]

Proponents of the NHI say that this proposed system is essential to fulfil this right. This, however, is not so. The alternative solutions earlier outlined would be far more effective in giving all South Africans access to quality health care on a basis that everyone, helped in particular by state-funded health vouchers, would be able to afford.

By contrast, the proposed NHI system – far from bringing about increased access to health care on a progressive basis – will deprive many South Africans of the access to health care that 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 idea is also inconsistent with other guaranteed rights. Forced participation in the NHI Fund contradicts the right to freedom of association in Section 18 of the Bill of Rights. Confining medical schemes to complementary services – and thereby preventing them from remaining in business – is inconsistent with the right to property in Section 25 of the Constitution. Barring health care professionals from private practice – as the certificate of need and all the state controls implicit in 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.

Fortunately, however, it is not necessary for the government to breach the Constitution in order to achieve universal health coverage and high standards of health care for all. The reforms that will be effective in achieving these goals have also been outlined. All that is needed is the political will to adopt them.

South African Institute of Race Relations NPC **21st September 2018**

References

[1] (CCT73/05A) [2006] ZACC 12; 2007 (1) BCLR 47 (CC); 2006 (6) SA 416 (CC); 2016]ZACC 22
[2] Section 59(1), Constitution of the Republic of South Africa, 1996; *Minister for Health and another* v *New Clicks South Africa (Pty) Ltd and others*, [2005] ZACC 14, at para 630, emphasis supplied by the IRR; *Doctors for Life*, at para 145; *Land Access* judgment, at para 59
[3] SEIAS Guidelines, p3, May 2015
[4] Guidelines, p6
[5] Guidelines, p11
[6] Guidelines p7
[7] Ibid
[8] Department of Planning, Monitoring and Evaluation, 'Socio-Economic Impact Assessment System (SEIAS), Final Impact Assessment (Phase 2): White Paper on National Health Insurance, 11 May 2017
[9] SEIAS report,pp 26-28, 47-49
[10] SEIAS report, pp19-20
[11] Department of Health, National Health Act, National Health Insurance Policy: Towards Universal Health Coverage
[12] Anthea Jeffery, 'Pressing ahead with NHI Implementation', @*Liberty*, IRR, Issue 34, November 2017
[13] *Financial Mail* 19 July 2018
[14] See Part 5, NHI Bill]
[15] Jeffery, 'Pressing ahead with NHI Implementation', pp36-38; Anthea Jeffery, 'The NHI Proposal: Risking lives for no good reason, @*Liberty*, IRR, Issue 29, December 2016, p5
[16] Clause 38(6), NHI Bill; www.businesslive.co.za, 5 June 2018
[17] White Paper, page 40, Table 1
[18] 2017 White Paper, pp39-40, paras 200-201
[19] *Fast Facts*, February 2018, pp8, 6; *Business Report* 7 September 2018
[20] Kerry Cullinan and Amy Green, 'Massive changes proposed to private medical schemes, *Daily Maverick*, 26 June 2018, p1
[21] Table 2: Health expenditure in SA public and private sectors, 2012/13-2019/20, White Paper, p42; IRR calculations, check ask for handwritten page with my rough figures and check
[22] Ibid, p42, Table 2
[23] *Saturday Star* 12 December 2015

[24] White Paper, pp49-50, para 253
[25] SEIAS report, pp32-33
[26] Paul Harris and Julia Price, 'Discussion Paper on Access to Healthcare in South Africa and the Proposed National Health Insurance Plan, Prepared for the High Level Panel of Parliament', 26 June 2017, pp6, 13-14
[27] White Paper, p47, Table 3
[28] SEIAS report, pp26-27; www.sars.gov.za, 27 March 2018; *Fast Facts*, IRR, Johannesburg, February 2018, p11
[29] 2018 *South Africa Survey*, IRR, Johannesburg, 2018, pp196-197
[30] *Business Report* 19 September 2018; *Fast Facts*, February 2018, p8, citing National Treasury, Budget Review 2018; Dawie Roodt, address to Ad Hoc Property Group, Pretoria, 6 September 2018
[31] *Fast Facts*, February 2018, p6
[32] The Davis Tax Committee, 'Report on Financing a National Health Insurance for South Africa', March 2017, p44
[33] Clause 11(4), NHI Bill
[34] 2017 White Paper, page 3, para 1; page 24, Figure 4 and paras 108, 109; page 25, para 112; page 27, paras 128-131
[35] *Vancouver Sun* 7 June 2018
[36] The Davis Tax Committee, 'Report on Financing a National Health Insurance for South Africa', March 2017, pp44, 21
[37] *Business Day* 13 October 2016
[38] fin24.com 18 July 2017
[39] SEIAS report, p37
[40] Dr Johann Serfontein, Briefing to the Free Market Foundation, 19 July 2017
[41] Ian Ollis, 'Workers' Compensation Fund is in utter disarray', *Politicsweb.co.za*, 18 May 2015
[42] *Business Day* 5 July 2017
[43] Paul Harris and Julia Price, 'Discussion Paper on Access to Healthcare in South Africa and the Proposed National Health Insurance Plan', prepared for the High Level Panel of Parliament, 26 June 2017, p8; *The Star* 4 February, *The Times* 16 February, *Business Day* 2 June 2017
[44] Clauses 35(2), (3), (4), NHI Bill
[45] Clause 5(1)(k), NHI Bill
[46] Preamble, Clause 3(3), NHI Bill
[47] Dr Johann Serfontein, Presentation to the Free Market Foundation, 20 April 2016
[48] Dr Johann Serfontein, Briefing to the Free Market Foundation, 19 July 2017, slide 27; Office of Health Standards Compliance, *Annual Inspection Report 2015/2016*, p27; Health-e, 'Grim findings after health facilities inspected', *Daily Maverick*, 18 April 2017
[49] *The Citizen* 11 June, businesslive.co.za 5 June 2018; OHSC, Office of Health Standards Compliance, Annual Inspection Report 2016/17, June 2018, pp19-21
[50] OHSC, 2016/17 Annual Report, p178; Businesslive.co.za, 5 June 2018
[51] Clause 1, definitions, NHI Bill; *Business Day* 29 January 2015; www.huffingpost.co.za, 25 June 2018
[52] SEIAS report, p33
[53] Serfontein, FMF briefing, 19 July 2017, slide 10; White Paper, p42, Table 2; Council for Medical Schemes, 'The Medical Schemes Industry in 2016', *Annual Report 2016/17*, p128
[54] 2018 *South Africa Survey*, p625; Council for Medical Schemes, *Annual Report 2016/2017*, p130; 'Medical aid coverage by population group and sex', Table 4.2, in Statistics South Africa, *General Household Survey, 2016*, P0318
[55] White Paper, page 58, para 305; Clause 9(o), NHI Bill
[56] Johann Serfontein, Briefing to the Free Market Foundation, 20 April 2016
[57] *Business Day* 15 May, *The Times* 11 May 2017
[58] Anthea Jeffery, 'Pressing Ahead with NHI Implementation', *@Liberty*, IRR, Issue 34, November 2017, pp40-42
[59] Clause 32I(1), MSA Bill
[60] Clause 32I(2), MSA Bill
[61] Clause 32F(1)(a), MSA Bill]
[62] Clauses 32A, 32B(1), MSA Bill
[63] Clauses 32D(1), 32D(5), 32A(2), MSA Bill
[64] Clause 32D(6), MSA Bill
[65] news24.com, 21 June 2018
[66] 2017 White Paper, page 59, para 308; 2015 Draft White Paper, paras 401-402; Clause 34, MSA Bill
[67] Clause 9(o), NHI Bill

[68] *The Star* 7 March 2017; *Sunday Times* 23 July 2017
[69] Strategy and Tactics of the African National Congress, as adopted by the 54th National Conference 2017 (2017 S&T document)
[70] See, for example, Para 2.2.2, 2017 S&T document
[71] businesslive.co.za 20 June 2018
[72] World Health Organisation, Sustainable Development Goals, SDG 3.7; Draft White Paper, 2015, para 48, note 5
[73] SAPPF, Submission on NHI Financing to the Davis Tax Committee, 12 October 2016, para 43, emphasis supplied
[74] SAPPF Submission, page p3
[75] Harris and Price, Discussion Paper on Access to Healthcare, pp18-20, 7-9
[76] Ibid p8
[77] Democratic Alliance, Our Health Plan: The DA's Plan for Universal Health Coverage, prepared by Dr Wilmot James MP and Dr Heinrich Volmink MP, 16 November 2016, pp1-4, 8-17, 22-23
[78] *Business Day* 8 August 2017
[79] Free Market Foundation, 'Reforming South Africa's proposed healthcare financing reforms', September 2017, p3
[80] Free Market Foundation, ibid, pp6, 10, 11, 13, 15; See also Jasson Urbach, 'Paying for Intervention! How statutory intervention harms South African health care', Free Market Foundation, 2009, pp30, 24-26, 16-20
[81] *The Guardian* 18 May 2015
[82] *2017 South Africa Survey*, p252
[83] Section 27(1)(a), (2), Constitution of the Republic of South Africa, 1996