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Submission to National Department of Health

National Health Insurance Green Paper

Submitted by the Health Policy Unit

(A division of the Free Market Foundation)

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Table of Contents

Part A: Introduction

The Health Policy Unit

The Health Policy Unit (HPU) is dedicated to promoting a sound economic policy approach to the provision and funding of health care. The HPU maintains that the private supply of competitive health-care services and the incremental extension of private funding is the most effective method of supplying high quality health care to the entire South African population.

The HPU urges government to devote its limited health budget to the supply of services to the poor, to purchase an increasing percentage of those services from private providers, and to allow and encourage the rapid growth of the private healthcare sector, enabling it to provide services to an increasing percentage of the population.

The HPU is a division of the Free Market Foundation (Southern Africa), an independent non-profit policy organisation, which promotes and fosters an open society, the rule of law, personal liberty, and economic and press freedom as fundamental components of its advocacy of human rights and democracy based on classical liberal principles

Draft Policy on National Health Insurance

The National Department of Health (DOH) published the draft Policy on National Health Insurance (NHI) in the *Government Gazette* on 12 August 2011 (the Green Paper), and invited interested persons to submit comments and representations on the draft Green Paper policy proposal. The Health Policy Unit welcomes the opportunity to participate and provide input in this debate.

The current government is disturbed by the rapid growth of what it regards as "uncontrolled commercialisation" of private healthcare. However, private healthcare in South Africa is already heavily regulated and for the government to imply that this is "uncontrolled" suggests that its laws and regulations are ineffectual. We have seen substantial market movements in response to government's regulations, which display compliance with regulations and the effects of regulation. For example following the introduction of the Medical Schemes Act of 1998 South Africa witnessed a substantial consolidation of many medical schemes, whilst others exited the market.

The Green Paper suggests that the existence of a two-tier health care system in SA is the fundamental cause of the poor service provision and performance of the entire health care system. More specifically, the Green Paper seems to suggest that this poor performance is primarily the result of the existence of the private sector. This is a fundamentally flawed argument. The evidence to the contrary is that the existence of the private health care sector (in all its aspects) is highly beneficial to the people of South Africa, including the poorest members of the population. The Green Paper does not address the root cause of the poor performance of the overall South African health care sector, which according to international surveys is detrimentally affected by the poor performance of the public health sector. The proposed NHI will not and cannot address South Africa's health care deficiencies fundamentally since the Department has misdiagnosed the problem.

Part B: Detailed submission

Introduction

The opening sentence of the Green Paper states, "South Africa is in the process of introducing an innovative system of healthcare financing with far reaching consequences on the health of South Africans". This sentence seems to suggest that the government is going ahead regardless of the outcome of the public commentary and is thus a politically motivated event. Indeed the Green Paper creates a straw man by suggesting that the root cause of the problems within the South African healthcare is due to a so-called two tier system. In the first paragraph the Green Paper goes on to note, "NHI will ensure that everyone has access to appropriate, efficient and quality health services". However, considering South Africa's relatively small tax base and thus limited available pool of revenue and given our chronic levels of unemployment this is a gargantuan commitment that will be unattainable given budgetary constraints.

Paragraph 2 of the Green Paper notes, "[The NHI] will promote equity and efficiency so as to ensure that all South Africans have access to affordable, quality healthcare services regardless of their socio-economic status". But the Green Paper provides little or no detail on how exactly this commitment will be achieved. For example, it does not define what it means by "efficiency". In the private sector efficiency is measured by profits and return on investment. Since the public sector is not subject to the disciplines imposed by profit and loss it will be impossible to objectively measure how "efficiently" the sector is performing. Furthermore, it not clear how the Green Paper defines "affordable" when in the same sentence the Green Paper suggests that patients will be provided with care "regardless of their socio-economic status". This seems to imply that the Green Paper defines affordable as free.

Paragraph 3 of the Green Paper presents a familiar, yet widely disseminated fabrication about the so-called 84-16 split between those served by the public and private sectors. The Green Paper makes a fundamental error by assuming, rather simplistically, that since 16 per cent of the population is covered by a medical scheme that the remaining 84 per cent of the population must be dependent on the public sector for healthcare, and uses this as grounds for the introduction of the NHI. This is a crude and incorrect assumption and is not a true representation of the facts. The Green Paper largely overlooks the fact that a significant proportion of the population does not attend public health facilities and prefers to pay out-of-pocket to receive care from private healthcare providers. In addition, the claim that the "private sector" is supposedly not "doing its share" is doubly unwarranted in that "the private sector" is paying 100% of the costs of all health care provided in South Africa, part through medical schemes, insurance and out-of-pocket expenses, and the rest though the taxes out of which government provides public health care.

Given the revealed preferences of South Africans, to access private medical facilities whenever possible, reforms should focus on enrolling more individuals in private medical schemes. This will reduce the burden on public sector healthcare facilities and free up scarce taxpayer resources so that the government can focus on purchasing the best available care from privately competing healthcare providers. Far from marginalising medical schemes, government should be promoting their proliferation because regular small fixed payments to a medical scheme or insurance company to cover catastrophic events would make intuitive sense, as opposed to the rare but devastating high out-of-pocket payments required when illness strikes.

In paragraph 3, the Green Paper notes that *choice* is a desirable outcome when it states, "This means that those with medical scheme cover have a choice of providers operating in the private sector

which is not extended to the rest of population". Indeed, the key to improving healthcare outcomes in SA is to increase the amount of competition in the private sector, which will in turn drive down prices and increase the available choices to SA citizens. In contrast, introducing an NHI will only serve to limit choice and increase prices and reduce the quality of service.

Moreover it must be noted that individuals *voluntarily* contribute to medical schemes. This is not the case under the NHI, where certain groups of people will be *forced* based on their socio-economic status, or else face prosecution and potentially jail time for not contributing to the proposed system. Contributions to private medical schemes are also over and above what South Africans already contribute to public health facilities via the tax system.

The Green Paper proposes South Africa's own version of a centrally planned, socialised health system, in which the facilities, the equipment, the doctors, nurses and other medical professionals, whether in the public or private sector, have been regulated, licensed, certified, approved and price-controlled by the government.

The centrally planned NHI as proposed by the Green Paper largely blames the private sector for the country's failure to address core health care deficiencies and seems to suggest that the poor performance of the public health sector can be addressed by passing legislation. The Green Paper largely ignores the failures of the country's own public health system and the evidence from other countries with socialised health systems that demonstrate these systems are inefficient, expensive, lack sophisticated medical equipment, have long waiting lists for medical procedures and appointments with specialists, do not provide equal access to and equal treatment for all citizens, provide lower quality health care than private systems, control costs by rationing care and medical technology, and fall far short of attaining their lofty ideals.

Paragraph 4 of the Green Paper notes, "The public sector has disproportionately less human resources that the private sector...". This problem is no fault of the private sector. The government is responsible for restrictions on the training of healthcare personnel in SA and the reason medical personnel choose to move to the private sector or abroad is partly due to the poor state of affairs in the public sector. Indeed South Africa has insufficient healthcare personnel because of government interference in the education sector.

Information from SA medical schools suggests that one third to one half of their graduates leave this country to seek work in the developed world. SA's chronic shortage of skilled healthcare professionals continues unabated and the situation worsens by the day. Despite this, the Department of Health continues to restrict the supply of doctors by limiting the number of foreign health professionals entering SA and the number of positions available at the eight government-run medical schools across the country. The number of places available to train doctors is determined by the Health Professions Council of South Africa (HPCSA) and is limited to approximately 1,300 positions each year. This situation has remained relatively unchanged since the 1970's despite the fact that the demand for these positions increases every year.

According to a study conducted by the OECD in 2003 entitled 'South African born workers, practising a medical profession in certain OECD member countries in 2001', "Despite substantial financial incentives, many commentators, including some employee representatives, emphasise that in many cases pay is not the prime motive for leaving the country. Deteriorating working conditions in the public sector is one factor that is frequently mentioned. A significant increase in the workload, due to wider access to health care, and the uneven distribution of human resources between the private and public sector, and urban and rural areas, leads health professionals to seek better working conditions. Exposure to AIDS and other endemic infectious diseases, like TB, insecurity resulting from

delinquency, the lack of suitable equipment, and social and racial factors, also are cited as difficulties that specifically affect the practice of medicine".

Despite the Green Paper stating there is an uneven split between the public and private sectors it does not actually provide any figures to substantiate this statement. Given the worldwide shortage in skilled healthcare personnel, it is more likely that both the public and private sectors are understaffed, yet the Green Paper provides no insights into how the government intends to deal with the systemic problem of a lack of skilled healthcare personnel in South Africa.

The HPU contends that an immediate response to alleviate the chronic shortages of skilled medical personnel would be to let foreign health professionals practise in SA. The majority of foreign doctors in SA work in rural areas – without them the rural system would be sure to collapse. Although there are no definitive figures available as to what it costs to put an individual through medical school, it is widely accepted that it is far cheaper to recruit a foreign doctor than to train a doctor in South Africa. Furthermore, foreign doctors with the appropriate skills can alleviate the chronic shortages virtually overnight whereas training doctors in South Africa takes several years.

Thus a long-term strategy to alleviate the chronic staff shortages requires the government, and more specifically, the Department of Education, to relax the controls on tertiary education facilities, make entrance to these facilities less restrictive, and allow the private sector to provide a large percentage of tertiary medical education for doctors. If private education facilities are established they could operate on either a for-profit or non-profit basis and would have the potential to relieve a significant part of the burden currently faced by the public sector.

Consider the progress that the private sector has achieved in the training of nurses. With the closure of many of the public sector nursing colleges in the 1990's, severe shortages ensued. According to a discussion document tabled in SA's Parliament, a total of 2,629 registered nurses graduated from these public sector facilities in 1996, ten years later this figure plummeted to 1,493. But the private hospital sector in SA has been investing significantly and intensively in both the financing and training of nurses to try and fill the gap.

According to the South African Nursing Council, in 2006 the private sector funded and trained approximately 54 per cent of the registered nurses who qualified in SA. If the government allowed the private sector to train and certify doctors and nurses and stopped artificially restricting the supply of skilled health professionals, the situation would rapidly improve. SA's private hospitals are well-established centres of excellence and world renowned for their high levels of care. Privately run education facilities, if conducted in co-operation with private hospitals, have the potential to attract internationally recognised lecturers, which will increase the available pool of knowledge, as well as international students, who will be prepared to remain and work in SA. Privately run medical schools will not solve the chronic medical staff shortage overnight, but will assist the government's long-term efforts to increase the number of medical professionals in SA

The private health sector is not responsible for the poor health performance of the public sector – for this the South African government is entirely to blame. We once again reiterate that the proposed rationale for introducing an NHI in SA is flawed. The entire South African population already has access to health care and they currently have a choice of paying for services through the private sector or attending public healthcare facilities. A substantial obstacle an individual faces in the public sector is the significant waiting periods coupled with a poor level of service. It is for this reason that people choose to pay out of pocket and access the private sector. The Green Paper itself acknowledges that "The public health sector will have to be significantly changed so as to shed the

image of poor quality services that have been scientifically shown to be a major barrier to access (Bennett & Gilson, 2003)". We will return to this quote below.

Paragraph 5 of the Green Paper states, "The South African health system is inequitable, with the privileged few having disproportionate access to health services. There is recognition that this system is neither rational nor fair". As noted in the previous paragraph all South Africans effectively do have access to healthcare either via self-provision or through the public healthcare system. Many people, including government Ministers, Members of Parliament, senior government officials, and a host of other people supported by taxpayers, are among the "privileged few having disproportionate access to health care". These same people are among "the privileged few having disproportionate access to" superior transport, housing, food, clothing, entertainment, and many other privileges. Do we now declare that "this system is neither rational nor fair" and work out a scheme to share these privileges with the people who do not have access to them? Or do we recognise that people are entitled to work for, and secure for themselves, better healthcare, transport, housing, food, clothing, entertainment and other privileges, especially if they pay for them entirely out of their own resources?

The reality of life on our planet is that while resources are limited, the wants of people are unlimited. When we cannot have as much of everything as we would like, we are forced to choose from whatever alternatives are on offer. When resources are used to produce one article or service, it reduces their availability to produce others. Similarly, government's resource, the pool of revenue available to it to fund competing alternatives such as policing, schooling and health care is limited, whereas the people's demand for these services is limitless, especially when they are perceived as 'free'. The amount of funds government uses to provide one service, leaves it with that much less to provide every other one.

Forcing individual's to pay for each other's medical expenses is neither fair nor rational. Indeed if the government introduces a policy of forcing A to pay for B's medical care and forcing B to pay for A's, while A and B may be tricked into thinking that someone else is paying and that they are receiving free medical care, in reality neither are. Ultimately, such a system encourages both A and B to overspend on health care. Neither takes responsibility for their own medical care requirements because they are under the illusion that someone else is paying.

Paragraph 5 goes on to note that "...NHI is intended to ensure that all South African citizens and legal residents will benefit from healthcare financing on an equitable and sustainable basis". In reality people's healthcare needs vary significantly. In general the very young and elderly individuals have far higher healthcare requirements than the rest of the population. Thus healthcare financing on an equitable basis is simply not feasible or appropriate. Furthermore, by introducing the concept of equality in healthcare financing one also has to be mindful of the moral hazard involved. Because individual A does not bear the full consequences and responsibilities of his/her actions, he/she will have a tendency to act less carefully than they otherwise would, knowing that individual B bears some of the responsibility for the consequences their actions. For example, individual A might not exercise regularly smoke and drink heavily, leaving an unfair burden on individual B to cover individual A's medical expenses. This system is neither fair nor sustainable because there are no economic incentives for either individual to act rationally.

Problem Statement

Paragraph 12 of the Green Paper attempts to draw a parallel between the South African healthcare system and the 2008 World Health Report produced by the World Health Organisation, which details three trends that undermine the improvement of health outcomes globally namely: "Hospital centrism", "Fragmentation" and "Uncontrolled commercialism". However, no such analogy can be drawn because there is no evidence to support the comparison. More specifically, paragraph 12 makes the bold pronouncement that "...the South African two-tier healthcare system, which are [sic] unsustainable, destructive, very costly and highly curative or hospi-centric".

Paragraph 14 of the Green Paper notes the poor track record of the public healthcare system by recognising the fact that poor quality services act as a barrier to access. Paragraph 14 states, "The public health sector will have to be significantly changed so as to shed the image of poor quality services that have been scientifically shown to be a major barrier to access (Benner & Gilson, 2003)". Although this Green Paper makes sweeping statements about future improvements to the public health sector, the NHI focuses on expanding the role of the public sector, whereas the focus should be on improving the quality of health care to the poorest people in the country while not meddling with those people who are providing health care for themselves from their own resources. The NHI is no elixir that will fix public health care by passage of legislation, or by throwing more money at it. Fixing public health care will require more than money, it will require a change of ethos within the system, especially the adoption of an ethos that dedicates the utilisation of budgetary resources to providing the best quality care to patients. Given the poor performance of the public health care sector the proposed NHI will simply perpetuate this poor performance whilst consuming more resources. Indeed there is no evidence to indicate otherwise. Simply pouring more money into a dysfunctional system will not improve the quality of services. In fact it rewards under-achievement, provides no incentive to improve and seems to be obstinately aimed at creating massive disincentives in the private health care sector.

Paragraph 15 refers to costs of services in the private healthcare sector and states, "Evidently, the private health sector will not be sustainable over the medium to long term" but once again fails to provide the evidence to support this assertion. There is a clear anti-private sector bias in this statement. Once again it must be noted that people voluntarily choose to attend private healthcare facilities and to make contributions to private medical schemes. Unlike the proposed NHI, people are not forced to make payments. Moreover, if the public sector was a viable alternative, people would have no qualms about using the service, but this is not the case. The government's most important role is to create an environment that leads to the rapid growth of a competitive private sector as opposed to introducing draconian legislation that limits its role and retards its expansion. With increased competition individuals will have more choices, prices will fall and quality will improve.

Limitations on the building of new private hospitals and clinics constitute a prime example of mystifying constraints that limit new entrants and reduce potential competition in the health care field. More hospital beds mean more competition and lower costs for patients. The DOH complains about the cost of private hospitalisation but does not do the one thing that would ensure that prices are not excessive, which is to entirely remove constraints on the number of hospital beds that can be provided. There should be general rules applicable to all hospitals and clinics to ensure patient safety and anyone complying with those requirements should be allowed to open a hospital, clinic, or day medical centre wherever they wish.

Another constraint among the many in the medical field is the prohibition on the employ of doctors and medical specialists by private hospitals. The Green Paper maintains that there are shortages in

the medical field but there are constraints on provision everywhere. Constraints on the training of doctors and nurses; constraints on the building of medical facilities, purchasing medical equipment, hiring doctors and a host of other blockages that prevent the development of the lowest cost, best quality of provision of services in the medical field.

The Burden of Disease in South Africa

Paragraphs 22 and 23 make comments on the quality of healthcare in the public sector. More specifically, paragraph 23 states, "Given that there are concerns about quality at public sector facilities, there is preference by the public for services in the private sector which may largely be funded out of pocket". This sentence is revealing and raises the question of why the government wishes to expand the role of the public sector when there is a revealed preference by South African citizens to receive treatment in private healthcare facilities.

Healthcare Expenditure in South Africa

Paragraph 24 states, "South Africa already spends 8.5% of its GDP on health, way above what the WHO recommends. Despite this high expenditure the health outcomes remain poor when compared to similar middle-income countries. This poor performance has been attributed mainly to the inequities between the public and private sector". Once again there is no evidence provided that proves that health inequities are the cause of poor health outcomes. This paragraph correctly points out that SA already spends a considerable amount of money on health, yet the health status of South Africans compared to people in other middle-income developing countries is relatively poor. There are a number of factors that influence health status such as income, education and access to basic services such as water and sanitation. A high level of spending on health services will not, by itself, result in good health. Indeed as we suggested previously simply pouring more money into a dysfunctional system will not solve the underlying problems.

Paragraph 25 quotes statistics from Schieber et al 2006 and reveals that wealthier countries spend more on healthcare than lower income countries. The correlation between wealth and health is by no means serendipitous – as nations get wealthier, more money becomes available for expenditure on health care. The landmark article by economists Lant Pritchett and Lawrence Summers shows the dramatic effect that increases in incomes can have on health. Pritchett and Summers found a strong causative effect of income on infant mortality and demonstrate that if the developing world's growth rate had been 1.5 percentage points higher in the 1980s, half a million infant deaths would have been averted

During the second half of the twentieth century, the diffusion of technology from rich to lower-income countries, as well as greater wealth in lower-income countries, led to what has been described as the third of three great waves of mortality decline. Increased access to safe water and sanitation in lower-income countries, as well as greater access to basic public health services, greater knowledge of basic hygiene, and new technological developments (such as antibiotics and tests for early diagnosis) were instrumental in reducing mortality rates across the globe. Revolutions in agriculture also resulted in increased food supplies throughout the world. The combination of these factors, facilitated by trade between rich and poor nations, led to longer life expectancies worldwide – not just in the richest nations. The lesson here is if South Africa wants to improve its health outcomes in needs to grow

One of the surest ways to increase wealth in a country is to embark on trade and economic reforms that result in higher levels of economic freedom. The foundations of economic freedom are personal choice, voluntary exchange, freedom to compete and security of privately owned property. Without voluntary exchange and entrepreneurial activity coordinated through markets, modern living standards would be impossible. There is ample evidence which proves that economically free countries are wealthier and healthier than those that suppress their citizen's freedoms. For example see Fraser Institute's *Economic Freedom of the World* and the Heritage Foundation's *Index of Economic Freedom*

Paragraph 27 states, "In real terms, contribution rates per medical scheme beneficiary have doubled over a seven-year period". However, the government is largely responsible for the cost escalations within this sector by introducing draconian legislation namely the Medical Schemes Act of 1998 that effectively prevents lower income individuals from joining medical schemes. The main aim of the Act of 1998 was to extend the cover enjoyed by beneficiaries as well as increase the number of beneficiaries. To achieve these goals, the Act made sweeping changes to existing legislation claiming that these amendments were necessary in order to achieve 'social solidarity'. Four main changes were introduced, namely, open enrolment, community rating, statutory solvency requirements, and the introduction of a comprehensive package of hospital and outpatient services that all schemes are compelled to provide – referred to as prescribed minimum benefits (PMBs).

The so-called act of 'social solidarity' has the effect of driving lower-income and healthy people out of the market or preventing them from even entering the market. The consequence is that the risk pool of insured people becomes smaller and less healthy, driving up contribution levels and making health insurance unaffordable. This vicious cycle could eventually lead to a situation where the entire health insurance market could disappear altogether.

PMBs act as a *de facto* entry barrier because they prevent actuaries from designing low-income insurance packages. When benefits are determined politically, rather than by what individuals want, the benefit package and the costs required to cover them expand. The consequence is that low cost medical schemes that cover the specific basic needs of low income people cannot be designed accordingly. To increase the number of beneficiaries covered and to reduce the cost of medical scheme options, government needs to remove PMBs. Alternatively, it could allow certain schemes at the low end of the market to be exempted from PMBs to allow actuaries to devise options that cater for low income individuals

Medical Schemes Industry

Paragraph 32 refers to the sustainability of medical schemes and the fact that "A number of medical schemes have collapsed, been placed under curatorship or merged". This is not surprising given our explanation above. Solvency requirements for medical schemes enforced by government have also contributed to the demise or consolidation of medical schemes. Solvency requirements are a barrier to entry for new medical schemes trying to enter the private medical schemes market. It is unreasonable to expect potential entrants to raise enough capital, not only to fund their daily activities, but also to meet the statutory solvency requirements.

The consequences of the barriers created by statutory solvency requirements are entirely predictable. The CMS (2008) notes, "The decline in the number of medical schemes was due to amalgamations and liquidations. Some of the motivations cited by schemes upon amalgamation or liquidation were low membership, poor long-term financial sustainability, low economies of scale and difficult trading conditions".

The statutory solvency requirements introduce a considerable regulatory bias in favour of some medical schemes and against others. A scheme that has accumulated reserves that exceed the required minimum is in a better position to attract new members than one that has a shortfall. It will be particularly difficult for new medical schemes to enter the market and rapidly growing schemes will be at a disadvantage relative to slowly growing ones.

Paragraph 34 refers to “uncontrolled commercialism” within the medical schemes industry. However as noted previously the medical schemes industry is highly regulated through the Medical Schemes Act of 1998 as well as other legislation such as the government controlled prices within the private sector.

Out of Pocket Payments and Co-payments

Paragraphs 35-37 refer to out of pocket payments and co-payments. In paragraph 35 the Green Paper states, "Even for those who are covered by medical schemes, the extent of co-payments confirms that the current system does not provide full cover". However, this is private money and is a contractual agreement between the insurer and the insured and should be of no concern to government what happen between two freely contracting parties. Paragraph 35 goes on to state, "However, for those who are not on medical aid [out-of-pocket payments] could have catastrophic effects". As we noted previously this is in fact a justification for medical schemes because one would imagine that regular small fixed payments to a medical scheme would make intuitive sense, as opposed to the rare but devastating high out-of-pocket payments required when illness strikes. This may be a justification to extend private health insurance to all individuals but is not a justification for NHI (see response to paragraph 44 below).

In reference to the Health Care Finance Committee (1994), paragraph 43 of the Green Paper reveals that previous committees have demonstrated that an NHI is an inappropriate model for South African. Indeed, as part of her input to the 1994 Finance Committee established by the Department of Health to advise on NHI, Professor Anne Mills, Head of the Health Economics and Financing Programme of the London School of Hygiene and Tropical Medicine, succinctly summed up the situation regarding the appropriateness of a NHI-style system for SA by saying, "It is clearly financially unaffordable to offer universally either the benefits currently on offer in medical aid schemes, or free and complete in the public sector. Benefits would therefore have to be severely restricted. However, it is difficult to see how this can be achieved because the setting up of a universal scheme would raise expectations about access to care. Moreover, the scheme would put in place a financing mechanism before having in place the health service infrastructure to satisfy demand. Benefits would inevitably be unevenly available, causing justifiable grievance".

Health Care Finance Committee (1994)

Paragraph 44 states, "It was also suggested that there should be a multi-funder (or multi-payer) environment and that private funders, namely medical schemes, should act as financial intermediaries for channelling funds to providers". The merits of this option should be explored and debated as an alternative to the current NHI policy proposal. Indeed, if government views "health care for all" to be politically essential, it could require the population to privately and individually purchase mandatory cover to insure against catastrophic health-related events but otherwise leave people to provide for their own and their families' medical-related and other needs. Furthermore, instead of the government undertaking the management of taxpayer-provided funds intended for covering the medical costs of the poor itself, it should put the task out to tender. In the same way as people have many options to choose from in household insurance, car insurance and myriad other products and services, publicly-funded patients will then have a multiplicity of medical schemes to choose from. Competition between public hospitals and clinics, and with private facilities, to win business from taxpayer-funded public health insurance beneficiaries, will thrive and ensure that the best service for the best price is given.

Paragraph 44 also notes that the Health Care Finance Committee (1994) proposed "...that there should be a risk-equalisation mechanism between individual insurers to help stabilise the medical schemes industry". However a risk equalisation mechanism is not a very good idea, since it reduces competition amongst medical schemes and will ultimately result in increased prices for a captive consumer market (if private insurance is made mandatory).

National Health Insurance

Paragraph 50 states, "The rationale for introducing National Health Insurance is therefore to eliminate the current tiered system where those with the greatest need have the least access and have poor health outcomes". It is not clear why the mere existence of both a private health care sector and a public healthcare sector within the South African healthcare market is a valid justification for the introduction of NHI. Moreover, if this is the justification for NHI and given that the Green Paper explicitly states that the private sector will continue to operate under NHI, it is not clear how the two tier system will be eliminated? The HPU is concerned about how, exactly, the Green Paper determines who has the "greatest need".

Principles of National Health Insurance in South Africa

Paragraph 52 states, "The National Health Insurance will be guided by the following principles: The Right to Access; Social Solidarity; Effectiveness; Appropriateness; Equity; Affordability and Efficiency". However it is not clear from the Green Paper why it is necessary to establish an NHI to achieve these objectives. Many of these ideals are also simply inappropriate. For example, paragraph 52(f) states that services will be procured "at reasonable costs that recognise health as not just an ordinary commodity of trade but as a public good". Despite the fact that the Green Paper provides no detail as to how this principle is to be achieved, the HPU is of the opinion that health is in fact just an ordinary commodity like any other and thus should be treated as such. Healthcare services are most certainly not a public good because patients can be excluded (either through waiting times or through payments at both private and public facilities) from treatments and there is rivalry in consumption. Rivalry in consumption will always occur when there are limited numbers of healthcare personnel available to treat patients.

Objectives of National Health Insurance

Paragraph 55 pronounces the objectives of the National Health Insurance. But the Green Paper itself fails to provide the details on how the government will achieve these objectives and why these objectives cannot be addressed through incremental changes to the existing structures.

Socioeconomic Benefits of National Health Insurance

Paragraphs 56-61 refer to the potential socioeconomic benefits of National Health Insurance. As noted previously the correlation between wealth and health is by no means serendipitous – as nations get wealthier, more money becomes available for expenditure on health care. It is worth pointing out that causation runs in the direction of increased levels of wealth leading to better health outcomes. Indeed Pritchett and Summers found a strong causative effect of income on infant mortality and demonstrate that if the developing world's growth rate had been 1.5 percentage points higher in the 1980s, half a million infant deaths would have been averted. Thus South Africa needs to pursue policies that promote economic growth first. By focusing on a policy that places health first is tantamount to putting the cart before the horse. South Africa has a number of structural problems that should be addressed before we embark on an ambitious and costly policy such as the NHI that may or may not achieve the desired outcomes.

Paragraph 60 refers to the so called socioeconomic benefits conferred on Canada when it introduced its single payer healthcare financing model. As noted previously Canada's healthcare system is far from perfect and in fact has been ruled against by the Canadian court system. Moreover, Canada is not a valid comparison for a poor developing country such as South Africa. Canada has a significantly higher GDP per capita, a much higher rate of employment and vast amounts of healthcare resources relative to SA. However as noted previously despite these endowments, Canada is struggling to meet the demands of its patients under its 'free care for all' system. It is worth reiterating that the result of 'free care' are long waiting times and increased pressure on health workers and thus sub-standard levels of care.

Economic Impact Modelling

Paragraph 61 makes reference to macro-economic modelling undertaken by the National Treasury. Given the fact that there are no details on what exactly will be covered under the NHI it is difficult to imagine how the Treasury produced a macroeconomic model. It is thus not surprising that the results revealed that "National Health Insurance could have positive or negative implications...". Paragraph 61 also asserts that "[NHI] can have positive impacts in the long-run provided that it succeeds in improving the health indicators of the country, including significant improvement in life expectancy and child mortality". But these improvements are likely to occur in spite of NHI not because of it as the country develops. The final sentence of paragraph 61 states, "...for National Health Insurance to have this positive macro-economic implication it needs to address the current institutional and staff constraints...". This needs to occur in spite of NHI. We have noted previously how the government, and more specifically the department of education, artificially restrict the supply of doctors and nurses in SA and we have also provided suggestions as to how to alleviate the chronic shortages of skilled healthcare personnel.

Population Coverage under National Health Insurance

Paragraph 64 states that NHI will cover "all South Africans and permanent residents". As we have noted previously this is not a rational use of scarce taxpayer resources and is likely to adversely affect other areas of society that compete for taxpayer resources. Moreover, under NHI we can expect some medical scheme members at the low end of the market to terminate their contributions. This will effectively increase the burden on the State, when they assume financial responsibility for this segment of society, and will thus increase the load of the public sector.

The Re-engineered Primary Health Care System

Paragraph 69 states, "All members of the population will be entitled to a defined comprehensive package of health services at all levels of care…". However, the Green Paper does not explain the composition of the package and thus it is not possible to make any meaningful comments on the proposals.

District Clinical Specialist Support Teams

Paragraphs 71-73 refer to "District Clinical Specialist Support Teams". The ideals proposed in the Green Paper reveal a fundamental divergence from reality. As noted previously, South Africa has a fundamental lack of skilled healthcare personnel and NHI does little to address this issue but rather seeks to consume more resources in the areas where they are least required. There is a great deal of sense in taking the patient to the specialist rather than taking the specialist, with all necessary expensive equipment, to the rural patient. Does that mean there is greater danger to life in rural environments? In some ways, yes, when a medical specialist is needed, in other ways, definitely no, when all the risks of city life are taken into account! It's an international norm that skilled healthcare personnel are highly mobile. The South African government cannot prescribe to these individuals where they shall work. The result will be a mass exodus of specialists to countries where the conditions of employment are less onerous.

Healthcare Benefits under National Health Insurance

Paragraph 79 refers to the provision of a "comprehensive benefit package of care under NHI" but, as stated above, no detail is provided as to what is to be included and what is to be excluded from that package. We are therefore not able to comment on this important issue in a meaningful manner. Paragraph 79 also states, "[The comprehensive benefit package] also defines the types of services that are considered as achievable for the country commensurate with its resources". Although this does not answer the question of how much will be spent on the package of benefits, theoretically the answer is straightforward: we should only spend money on healthcare until, at the margin, a rand's worth of healthcare spend is equal to a rand's worth of some other good or service that we can buy. Practically, however, individuals have unique preferences and each individual faces a different set of circumstances, preferences and tolerance for risk. Thus there is a fundamental problem with NHI in that it seeks to treat all individuals as the same by establishing a comprehensive one-size-fits-all package of benefits.

Delivery of Primary Health Care Services through Private Providers

Paragraphs 85 and 86 refer to the "Delivery of Primary Health Care Services through Private Providers". Paragraph 86 states, "...[patients] must get the full range of primary care services required in one facility or comparable arrangement which does not inconvenience or require travel costs on the part of the patient". But the Green Paper does not specify what services are required and thus it's difficult to make a reasonable comment and debate whether the expectations are feasible or not.

Accreditation of Providers of Health Care Services

The Office of Health Standards Compliance

Paragraphs 97-99 refer to the "The Office of Health Standards Compliance". Firstly, we are concerned by the announcement made by Finance Minister, Mr Pravin Gordhan, in his February budget that R117-million has already been set aside to set up an Office of Health Standards

Compliance. Once again this is putting the cart before the horse and simply side-steps the necessary public debate on whether the establishment of this dedicated entity is necessary. Indeed given the lack of detail within the Green Paper on how this entity will operate it's doubtful whether this Orwellian sounding organisation will actually result in any improvements in the quality of healthcare services. Moreover, if a healthcare facility is not up to scratch what are the implications? Will the facility be shut down? If so this will be disastrous for those living in the community and will obviously reduce access to healthcare services – the exact opposite outcome of what the NHI purports to achieve. And if it is not shut down what incentives are there to improve? Given the diversity of the South African economy it is unlikely that one-size-fits-all approach will be appropriate. The OHSC also neglects individual outcomes, focussing instead on an aggregate approach within the targeted healthcare facilities.

The key to improving the quality of healthcare services is competition. The proposed NHI removes any scope for competition amongst healthcare providers and assumes that it can simply legislate the "required" level quality.

Payment of Providers under National Health Insurance

Paragraph 102 states "...accredited providers will be reimbursed using a risk-adjusted capitation system linked to a performance based mechanism". Although this concept is not defined we are concerned that a capitation system will result in an under-servicing of patients and removes any incentives for improving services. Indeed in paragraph 107 (c) the Green Paper itself states, "...under-servicing...is a common characteristic of many capitation based systems".

Like any other good a fee-for-service payment mechanism is the most efficient and effective and results in the best outcomes for patients, particularly in a competitive market where patients have a choice between various competing providers. The fee-for-service payment mechanism rewards those that provide the best quality service and punishes those that provide poor quality services. We therefore reject any proposals to introduce a capitation type system if such a system is to be forced on providers. Opting out must always be an option for service providers.

Principal Funding Mechanisms for National Health Insurance

Paragraph 114 and 115 refer to the "Principal Funding Mechanisms for National Health Insurance" The funding mechanism for NHI is a vital element of the proposal and without any details we cannot make any substantive comments. Given the lack of an adequate definition of a "comprehensive package of benefits" it is also difficult for us to provide a meaningful estimation of the cost to provide such services. Paragraph 114 states, "The funds can be from a combination of sources (e.g. the fiscus, employers and individuals). We caution however that increasing the financial burden on each of these entities does not occur without consequences. All money the fiscus (or government) 'earns' is ultimately derived from individuals. Increasing the tax burden on employers will likely result in fewer individuals being hired – exacerbating an already dire unemployment crisis in SA. Increasing the tax burden on individuals will result in less disposable income which will lead to lower levels of saving. Lower levels of saving in turn lead to lower levels of investment and without increased investment real wages will not increase.

Given South Africa's level of economic development and vast social problems, which include but are not limited to, a high level of unemployment, poverty and crime rate; it is seriously doubtful whether we are in a position to afford an ambitious proposal such as the NHI. We are of the view

that the introduction of an NHI will place an unnecessary and intolerable burden on SA's people that will be felt for many generations to come if it is introduced.

The Role of Co-payments under National Health Insurance

We are of the view that co-payments can be a useful tool for implementing cost containment measures and thus it is not feasible to dismiss their utility based on a narrow ideological bias.

How Much Will National Health Insurance Cost

Paragraphs 117-130 refer to costing estimate of the NHI. As noted previously given the dearth of available information it is not clear how the drafters of the NHI are able to estimate any costs. However, we reiterate our earlier stance: NHI is an inappropriate heavy-handed intervention given SAs current level of economic development and more pressing social challenges. Paragraph 126 states, "The intention is that the National Health Insurance benefits, to which all South Africans will be entitled, will be of sufficient range and quality that South Africans have a real choice as to whether to continue medical scheme membership or simply draw on their National Health Insurance entitlements". This is an extremely audacious statement and neglects the very real choices individuals will have to make with their limited budgets when a **mandatory** tax is foisted upon its citizens. Moreover, as we noted previously, making provisions to cover the entire South African population is not an efficient use of resources and will ultimately come at the expense of other sectors of society that may make better use of these scarce resources. Increasing the level of entitlements in South Africa is not sustainable and erodes individual freedoms in SA.

Paragraph 127 once again makes the unsubstantiated claim that, "...the present system of fragmentation, associated with high cost, curative and hospi-centric approach and excessive and unjustifiable charges, especially within the private health sector is unsustainable". This is a completely baseless assertion and has no place in a government document that is to be taken seriously.

The Establishment of the National Health Insurance Fund

Paragraph 132 of the Green Paper states, "[The National Health Insurance Fund] will be a single payer entity with sub-national offices to manage nationally negotiated contracts with all appropriately accredited and contracted healthcare providers". But the reasons why a single payer NHI will fail in SA can be found in a new Canadian study conducted by the Fraser Institute entitled: 'The Hidden Costs of Single Payer Health Insurance: A comparison of the United States and Canada'. According to the study, "In Canada, the government promises everyone that they have health insurance coverage for all medically necessary goods and services; but, in reality, access to treatment is often severely limited or restricted altogether". The study goes on to note, "In 1993, Canadian patients waited on average 9.3 weeks between the time they saw their family physician and the time they actually received specialist treatment. By 2007, the wait had increased to 18.3 weeks. Moreover, wait times in Canada are almost double the length that physicians consider clinically reasonable".

Canadian courts have seen the evidence and ruled that Canada's single payer health insurance monopoly makes people wait too long to get medically necessary care. The Canadian single payer

system is an example of what not to do in health care. The fact is that single payer systems are probably the worst way to achieve universal health insurance coverage. If Canada is currently witnessing the failure of its own single payer health insurance system, why would South Africa want to adopt such a system? Many Canadian trained and previously active physicians have left Canada for better opportunities and working conditions in the United States. The Fraser report notes that American doctors are not voting with their feet by moving to Canada for better opportunities or working conditions. As of 2002, there were 8,990 Canadian-trained physicians (a number equal to 13% of the Canadian physician workforce) actively practising in the United States. By contrast, only 519 American-trained physicians (equal to less than 1% of the American physician workforce) were working in Canada.

In order to correct the problems associated with government-run national health systems; the British NHS system is adopting a number of reforms where the private sector will play an increasing role in both financing and delivery of health care. In her paper entitled "NHS as State Failure: Lessons from the Reality of Nationalised Health Care", published in the December 2008 issue of Economic Affairs, Helen Evans, the Director of Nurses for Reform in the UK, notes, "Under the general rubric of Public Private Partnerships, the British government has championed a whole raft of market-oriented reforms".

These reforms include sending NHS patients to independent hospitals and clinics for care; asking the private sector to design, build and operate a new generation of Independent Sector Treatment Centres for the benefit of NHS patients, and a plan to establish a new generation of independent Foundation hospitals free from government control with a greater say over how they develop and raise capital. More importantly, an increasing number of British people are taking responsibility for their own health care. Approximately 7-million individuals have private medical insurance; 6-million have private health cash plans; 8-million pay privately for complementary therapies, and, each year, more than 250,000 pay for their own acute surgery.

In a welcome change to past legislation, seriously ill patients are now allowed to add their own money to the purchase of the most innovative medicines and treatments. Evans (2008) states, "Only by putting patients and consumers' interests first will healthcare really improve. It is only when healthcare is opened up to real consumers, trusted brands and new funding mechanisms – such as private health savings accounts – that nurses and other health professionals will find themselves working in environments with the incentives, resources and freedom to deliver responsive, popular and high quality care". Evans concludes her paper by stating, "As such, I reject egalitarianism and nationalisation in favour of healthy privatisation and competition. Ultimately, 20 years working in the NHS has taught me to believe in people and markets – not political diktat".

Under single payer models, governments inevitably impose price controls that limit the supply of medicines and access to treatment because they simply are not able to provide unlimited care to everyone. The slow and bureaucratic nature of government prevents new technologies from entering the system. Procedures are limited, as are the number of hospitals and the number of beds in those hospitals. This causes increased waiting times or millions being treated with outdated medical technologies. Evidence from the Fraser Institute study indicates that government control over hospital financing results in the capital deterioration of the facilities. Witness the decaying buildings as well as a chronic shortage of basic equipment in the majority of public hospitals in SA.

In view of the fact that public enterprises do not face competition, they do not have the same incentive as the private sector to modernise and maintain their facilities. In SA, it takes months, if not years, for the Department of Health to recognise the chronic shortages of equipment or health professionals, or that facilities are in desperate need of repair or renewal. Government central

planners cannot make timely decisions to modernise healthcare infrastructure. By contrast, consumer choice forces private sector hospitals constantly to modernise, evolve new strategies and invest in new technologies.

The Role of Medical Schemes

Paragraphs 137-139 refer to "The Role of Medical Schemes". Unlike the current private medical schemes where individuals voluntarily contribute their after tax incomes, "Membership to the National Health Insurance will be mandatory for all South Africans". As we have noted previously this does not provide "real choice" and is not a *fair* situation. Individuals should be allowed to opt out of the system that is a *real choice*. This choice can be accompanied by the proviso that individuals who opt out will not be able to access NHI accredited providers.

Paragraph 137 also states, "...there will be no tax *subsidies* for those who choose to continue with medical scheme cover" (authors emphasis added). Contributions to medical aids do not constitute a subsidy but rather a tax deduction. A tax deduction or exemption in respect of medical expenses is a government decision to refrain from taking money in the form of tax from taxpayers who are paying their own medical expenses and generally not using publicly provided medical care. A medical expense tax deduction is therefore not a subsidy. Government cannot subsidise you with your own money. Unlike subsidies, tax exemptions are far less prone to political manipulation. Tax exemptions benefit the intended beneficiary directly by lowering their tax liability. Subsidies, however, can be used for political reasons and, usually, are channelled to special interest groups. Taking one person's money in order to pay for another person's medical care is a subsidy.

Proposing to scrap tax deductions is simply a straw man. The reality is that government is intent on getting more money out of taxpayers at the expense of the private medical care sector. Eliminating tax deductions related to medical care will drive up the cost of medical scheme contributions, making it unaffordable for new members to join and forcing those at the margin to drop out. This could be a double edged sword for government as it will also increase the burden on the public sector as these individuals seek treatment at public health facilities.

Migration from the Current Health System into the National Health Insurance Environment

Paragraph 154 states, "Refinement of the revenue mobilisation strategy and pooling systems that will be implemented to ensure National Health Insurance provides the appropriate financial risk protection for the entire population and yields the full economies of scale from the publicly administered monopsony structure to support the single-purchaser National Health Insurance". We have already provided evidence demonstrating why a single payer system is not in the best interests of the patients. But it should be noted that a monopsony created by government is as equally problematic as a government created monopoly such as Eskom or Transnet. Like a monopolist the single purchaser or monopsonist may dictate terms to suppliers and this can only be controlled through the introduction of price controls. There is ample evidence to demonstrate the egregious effects of price controls on access to commodities and the subsequent formation of black markets.

Conclusion

The Green Paper does not explain how South Africa, which is a relatively poor country, will succeed in providing equitable health care to all through the envisaged NHI system, when wealthy countries have failed in their attempts to do so. When you add to that increased costs, antiquated infrastructure and an aging population, it is seriously doubtful whether the government is justified in wanting to introduce a NHI style system. New investment in the health sector is an essential priority given the potential crisis, but government has a poor track record in investing and maintaining public sector infrastructure, so it is not unreasonable to assume that this investment will not be forthcoming in the future. It is essential for the private sector to continue to play a significant role in SA's health care. Considering the fact that medical schemes provide the main channel for accessing private health care, it goes without saying that legislation which impacts this sector will directly affect the private provision of health care.

South Africans will lose their world-class private health care firms if government's health-care plans continue in the direction of nationalisation. Their freedom to choose their own health care, which is such a vital and personal service, will be severely curtailed under the proposed system. If government views "health care for all" to be politically essential, it could require the population to privately and individually purchase mandatory cover to insure against catastrophic health-related events but otherwise leave people to provide for their own and their families' medical-related and other needs.

Furthermore, instead of the government undertaking the management of taxpayer-provided funds intended for covering the medical costs of the poor itself, it should put the task out to tender. In the same way as people have many options to choose from in household insurance, car insurance and myriad other products and services, publicly-funded patients will then have a multiplicity of medical schemes to choose from. Competition between public hospitals and clinics, and with private facilities, to win business from taxpayer-funded public health insurance beneficiaries, will thrive and ensure that the best service for the best price is given.

Government's "laying the foundations for NHI" before the merits of the proposed system have been adequately discussed is putting the cart before the horse and comes at a cost for every person in South Africa, rich or poor.

Finally, the NHI Green Paper is thick on populist rhetoric and thin on critical details to make an informed decision on the health and economic impacts of the proposal. However we submit that far-reaching, wide-scale changes that rely on heavy-handed, top-down dictates seldom work in practice. Incremental, evolutionary type changes are far more practical because they allow one to see what is working and where. They also make it easier to adjust things that are revealed to be not working as well. In contrast, top-down, heavy-handed changes are extremely difficult to correct once implemented.

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