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SUBMISSION TO THE

DEPARTMENT OF HEALTH

ON THE

NATIONAL HEALTH INSURANCE BILL, 2019

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CONTENTS

Executive summary 1

About the Free Market Foundation 2

1. Introduction and background 2
2. The Constitution 3
3. The Rule of Law 5
4. Legal matters relating to the National Health Insurance Bill 8
5. Is National Health Insurance the appropriate vehicle to achieve universal health coverage? 16
6. Financing of National Health Insurance 19
7. The role of the private sector in achieving universal health coverage 22
8. Private medical schemes and so-called "social solidarity" 24
9. The cost impact of medical scheme legislation 27
10. Alternative solutions to the proposed NHI scheme 29

EXECUTIVE SUMMARY

On 26 July 2019, the South African government gazetted the National Health Insurance (NHI) Bill. South Africans, however, are no closer to understanding critical details such as how much the NHI scheme will cost, where the money to pay for it will come from, and where the country will obtain the additional personnel (both medical and bureaucratic) to staff the ambitious scheme.

When one considers the high levels of poverty and unemployment, the small tax base, and the poor performance of the public health sector, it is difficult to envision how a government-funded system that promises "free healthcare for all" is appropriate for South Africa. The consequences of the NHI proposal are entirely predictable. It would reduce the quantity and quality of South African healthcare provision; drive more healthcare professionals out of the country; create a bureaucracy entirely incapable of efficiently handling the huge volume of claims; and impose an unnecessary and intolerable burden on both government and taxpayers.

It is neither necessary nor appropriate for government to provide "free healthcare for all". Those who can pay for their own healthcare and, generally, do not rely on government provided services, must be allowed to continue to do so. The proposed mandatory payments into the central NHI Fund, however, will crowd out private voluntary insurance. Cash-strapped individuals will no longer be able to afford their voluntary private-insurance premiums when burdened with a mandatory NHI payment as well. Those unable to pay both premiums will be forced to use the already overstretched public health service.

Government's role should be to fund the healthcare needs of only the poorest and most vulnerable members of society and allow the private healthcare sector to grow, innovate and expand. Such a healthcare model would not only be good for South Africa's financial health but would lead to better health outcomes for the poor.

The constitutionality of the NHI Bill is also in serious doubt in light of the government's flagrant disregard for the imperative of the Rule of Law as contained in section 1(c) of the Constitution. The Bill vests unrestrained and, sometimes, completely unlimited powers in the hands of government officials in the form of discretionary or even law-making authority. It also completely disregards the Constitution's protections of the right of South Africans to access healthcare of their choice.

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ABOUT THE FREE MARKET FOUNDATION

The Free Market Foundation is an independent public benefit organisation founded in 1975 to promote and foster 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. It is financed by membership subscriptions, donations and sponsorships.

1. INTRODUCTION AND BACKGROUND

"The curious task of economics is to demonstrate to men how little they really know about what they imagine they can design."

Friedrich von Hayek, The Fatal Conceit: The Errors of Socialism

The Free Market Foundation (FMF) is dedicated to promoting a sound economic policy approach to the provision and funding of healthcare. The FMF maintains that the private supply of competitive healthcare services and the incremental extension of private funding is the most effective method of supplying high quality healthcare to the entire South African population.

The FMF 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, thus enabling it to provide services to an increasing percentage of the population.

"It is amazing that people who think we cannot afford to pay for doctors, hospitals, and medication somehow think that we can afford to pay for doctors, hospitals, medication and a government bureaucracy to administer it."

Thomas Sowell, Professor of Economics: Senior Fellow at the Hoover Institution, Stanford University

The consequences of adopting the proposed National Health Insurance (NHI) scheme are entirely predictable. We believe that it is neither necessary nor appropriate for government to provide "free healthcare for all" because doing so would not make good use of scarce taxpayer resources. Having taxpayers fund healthcare for those who cannot afford it is one thing, but to insist on interfering in the arrangements of those who can afford it, is counter-productive and unnecessary.

The proposed National Health Insurance will:

Reduce the quality of healthcare provision;

Drive more healthcare professionals out of the country;

Create a bureaucracy entirely incapable of handling the administrative and management complexity of such a diverse and substantive system; and

Impose an unnecessary and intolerable burden on both government and taxpayers.

We are concerned that despite the fact that the government has been working on its proposed healthcare plan for over a decade, South Africans are no closer to understanding any of the material details of the proposed NHI scheme including, but not limited to: how much the proposed scheme will cost; where the funding to finance the scheme will come from; and where we will obtain the additional personnel (both medical and bureaucratic) to staff the ambitious proposal. Yet government appears to be going ahead with the NHI scheme, and, in fact, is now in the second phase of implementation of the project. Given the conspicuous absence of the material details underlying the proposed scheme, we are concerned that this is a politically motivated event that will not materially improve the health outcomes of the poorest and most vulnerable members of society and may do more harm than good.

"Our fear is that the proposed NHI will fail to meet the expectations of the poor, will leave medical scheme members (including the working poor) worse off, will be massively expensive or even completely fiscally unaffordable, and will require far more doctors and nurses than are available. The danger is that it could well become a highly costly failure that will further increase frustration with service delivery."[1]

Professors Servaas van der Berg and Heather McLeod

2. THE CONSTITUTION

2.1 Values and rights

The Constitution contains various provisions, especially in the Bill of Rights, that protect the freedom of South Africans to determine their own affairs and destinies, including matters of healthcare. This can be summed up in the notion of freedom of choice, or freedom of enterprise.

The most important provision underlying all the other provisions is found in section 1 of the Constitution – the Founding Provisions. Section 1(a) provides that South Africa is founded on "[h]uman dignity, the achievement of equality and the advancement of human rights **and freedoms**" (our emphasis). This provision permeates all the provisions of the Bill of Rights by virtue of being a founding value.

Other provisions relevant to freedom of choice include the following:

Section 7(1) provides that the Bill of Rights "enshrines the rights of all people in our country and affirms the democratic values of human dignity, equality and **freedom**" (our emphasis).

Section 9(2) provides that the right to equality "includes the full and equal enjoyment of **all rights and freedoms**" (our emphasis).

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1 Van der Berg, S. and Heather McCleod (2009) Crude NHI plan threatens to make a bad situation worse. Business Day. Available at: http://www.bdlive.co.za/articles/2009/09/04/crude-nhi-plan-threatens-to-make-a-bad-situation-worse

Section 10 provides that "[e]veryone has inherent dignity and the right to have their dignity respected and protected". According to the Department of Justice and Correctional Services, this means that "[n]o person should be perceived or treated merely as instruments or objects of the will of others. Every person is entitled to equal concern and to equal respect".[2]

Section 12(1)(a) provides that everyone has the right "not to be deprived of freedom arbitrarily or without **just** cause" and section 12(1)(c) guarantees the right of everyone "to be free from all forms of violence from **either public or private sources**" (our emphases).

Section 13 prohibits "slavery, servitude or forced labour", the converse of which will also be true: forced unemployment or labour disassociation.

Section 14 guarantees the right to privacy, meaning private affairs should not be interfered with or monitored without consent.

Section 18 provides that "[e]veryone has the right to freedom of association". This right means that natural or juristic persons may associate or disassociate with whomever they wish and cannot be forced by law or other coercive means to associate or disassociate.

Section 22 provides that all citizens have "the right to choose their trade, occupation or profession freely. The practice of a trade, occupation or profession may be regulated by law". The language of the provision is clear, in that the *practice*, but not the *choice*, of profession may be *regulated,* but not *prohibited*. To read prohibition into regulation would make the entirety of the provision and the 'right' redundant. No provision in the Constitution may be construed as being redundant or inconsequential.

With reference to healthcare specifically, section 27(1)(a) of the Constitution provides that, "Everyone has the right to have access to health care services, including reproductive health care". This, read with the above, clearly implies that South Africans have the right to freely choose their healthcare service providers and services. While the State is obliged in section 27(2) to "take reasonable legislative and other measures … to achieve the progressive realisation of [this right]", this provision cannot be read to mean the State may in the process violate the freedom of South Africans to exercise, on their own, their right to access to healthcare.

2.2 The nature of rights and their limitation

Chapter 2 of the Constitution – the Bill of Rights – does not 'create' rights, but merely protects pre-existing rights from infringement. Section 7(1) states that the Bill of Rights "enshrines" the rights, not creates them. Enshrining something, in the constitutional sense, means to place that thing somewhere where it is protected, in this case, in a constitution.[3] South Africans have rights outside of the Constitution, and, if a provision in the Bill of Rights is repealed, that does not mean South Africans 'lose' that right. If this were the case, there would be little use in referring to rights as 'human' rights, as section 1 and the Preamble of the Constitution do. South

[2] http://www.justice.gov.za/brochure/2014_ConstitutionRights.pdf/.
[3] https://dictionary.cambridge.org/dictionary/english/enshrine.

Africans are all rights-bearing entities because we are humans with dignity and individuality, not because government has 'given' us those rights.

The rights in the Bill of Rights can be limited by operation of section 36, but the basic essence of the right in question must remain. Indeed, if protection of human rights is removed from the Constitution or otherwise perverted through legislative 'limitation', South Africa's constitutional project will be severely undermined in that the highest law will continue to recognise the rights in question but will not adequately protect them. This is not a situation South Africans would want to find themselves in. By implying that government can extinguish rights simply by enacting legislation dressed in the garb of 'protecting' the people while undermining their freedom, the impression is created that rights are an idea owned by the State and not the people. This would be faulty according to both human rights theory and the logic of the Constitution itself.

3. THE RULE OF LAW

Section 1(c) of the Constitution provides that South Africa is founded upon the supremacy of the Constitution and the Rule of Law. Section 2 provides that any law or conduct that does not accord with this reality is invalid. This co-equal supremacy between the text of the Constitution and the doctrine of the Rule of Law remains underemphasised in South African jurisprudence, but it is important to note for the purposes of this submission.

The Board of Advisors of the FMF's Rule of Law Project formulated the following ten Imperatives of the Rule of Law:

> **1st Imperative:** All law must be clear, predictable, accessible, not contradictory, and shall not have retrospective effect.
>
> **2nd Imperative:** All legislation that makes provision for discretionary powers must also incorporate the objective criteria by which those powers are to be exercised. The enabling legislation must, in addition, stipulate the purpose or purposes for which the powers may be exercised.
>
> **3rd Imperative:** All law must apply the principle of equality before the law.
>
> **4th Imperative:** All law must be applied fairly, impartially, and without fear, favour or prejudice.
>
> **5th Imperative:** The sole legitimate authority for making substantive law rests with the legislature, which authority shall not be delegated to any other entity.
>
> **6th Imperative:** No law shall have the aim or the effect of circumventing the final authority of the courts.
>
> **7th Imperative:** No one may be deprived of or have their property expropriated, except if done with due process for the public interest and in exchange for compensation that is just and market-related.

8th Imperative: The law shall afford adequate protection of classical individual rights.

9th Imperative: All law must comply with the overriding principle of reasonableness, which comprehends rationality, proportionality, and effectiveness.

10th Imperative: The legislature and organs of state shall observe due process in the rational exercise of their authority.

One of the Constitutional Court's most comprehensive descriptions of what the Rule of Law means was in the case of *Van der Walt v Metcash Trading Ltd*. In that case, Madala J said the following:

> "[65] The doctrine of the rule of law is a fundamental postulate of our constitutional structure. This is not only explicitly stated in section 1 of the Constitution but it permeates the entire Constitution. The rule of law has as some of its basic tenets:
>
> 1. the absence of arbitrary power – which encompasses the view that no person in authority enjoys wide unlimited discretionary or arbitrary powers;
>
> 2. equality before the law – which means that every person, whatever his/her station in life is subject to the ordinary law and jurisdiction of the ordinary courts.
>
> 3. the legal protection of certain basic human rights.
>
> [66] The concept of the rule of law has no fixed connotation but its broad sweep and emphasis is on the absence of arbitrary power. In the Indian context Justice Bhagwati stated that:
>
> 'the rule of law excludes arbitrariness and unreasonableness.'
>
> We would also add that it excludes unpredictability. In the present case that unpredictability shows clearly in the fact that different outcomes resulted from an equal application of the law."[4]

The Rule of Law thus:

Permeates the entire Constitution.

Prohibits unlimited arbitrary or discretionary powers.

Requires equality before the law.

Excludes arbitrariness and unreasonableness.

Excludes unpredictability.

[4] *Van der Walt v Metcash Trading Ltd* 2002 (4) SA 317 (CC) at paras 65-66. Citations omitted.

The Good Law Project's report, *Principles of Good Law,* largely echoed this, saying:

> "The rule of law requires that laws should be certain, ascertainable in advance, predictable, unambiguous, not retrospective, not subject to constant change, and applied equally without unjustified differentiation."[5]

The report also identifies four threats to the Rule of Law,[6] the most relevant of which, for purposes of this submission, is the following:

> "[The Rule of Law is threatened] when laws are such that it is impossible to comply with them, and so are applied by **arbitrary discretion** […]"

Friedrich von Hayek wrote:

> "The ultimate legislator can never limit his own powers by law, because he can always abrogate any law he has made. The rule of law is therefore not a rule of the law, but a rule concerning what the law ought to be, a meta-legal doctrine or a political ideal." [7]

What is profound in Von Hayek's quote is that he points out that *the* Rule of Law is not the same as *a* rule of *the* law. Indeed, any new Act of Parliament or municipal by-law creates and repeals multiple 'rules of law' on a regular basis – expropriation without compensation would be an example of 'a' rule of 'the' law. The Rule of Law is a doctrine, which, as the Constitutional Court implied in *Van der Walt*, permeates all law, including the Constitution itself.

Albert Venn Dicey, known for his *Introduction to the Study of the Law of the Constitution*, and considered a father of the concept of the Rule of Law, wrote that the Rule of Law is "the absolute supremacy or predominance of regular law as opposed to the influence of arbitrary power, and excludes the existence of arbitrariness, of prerogative, or even wide discretionary authority on the part of the government".[8]

Dicey writes "the rule of law is contrasted with every system of government based on the exercise by persons in authority of wide, arbitrary, or discretionary powers of constraint".[9] He continues, saying the Rule of Law means "the absolute supremacy or predominance of regular law as opposed to the influence of arbitrary power, and excludes the existence of arbitrariness, of prerogative, or even of wide discretionary authority on the part of the government".[10]

The opposition to arbitrary power should not be construed as opposition to discretion in and of itself. Officials use discretion to determine which rules to apply to which situation, and thus some discretionary power is a

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5 Good Law Project. *Principles of Good Law.* (2015). 14.
6 Good Law Project 29.
7 Von Hayek FA. *The Constitution of Liberty.* (1960). 206.
8 Dicey AV. *Introduction to the Study of the Law of the Constitution.* (1959, 10th edition). 202-203.
9 Dicey 184.
10 Dicey 198.

natural consequence of any system of legal rules. However, the discretion must be exercised per criteria which accord with the principles of the Rule of Law and the decision itself must also accord with those principles.

A common example of arbitrary discretion is when a statute or regulation empowers an official to make a decision "in the public interest". What is and what is not "in the public interest" is a topic of much debate and, to empower officials to apply the force of law in such a manner, bestows upon them near-absolute room for arbitrariness. The "public interest", however, can be one criterion among other, more specific and unambiguous criteria.

The fact that some discretion should be allowed is a truism; however, the principle that officials may not make decisions of a substantive nature still applies. Any decision by an official must be of an enforcement nature, i.e. they must do what the legislation *substantively* requires. For instance, an official cannot impose a sectoral minimum wage. The determination of a minimum wage is properly a legislative responsibility because it is of a substantive nature rather than mere enforcement. Unfortunately, the Basic Conditions of Employment Act gives the Minister of Labour the authority to make "sectoral determinations" – which includes determining a minimum wage – which is a clear violation of the Rule of Law and the separation of powers.[11]

4. LEGAL MATTERS RELATING TO THE NATIONAL HEALTH INSURANCE BILL

The NHI Bill is not ready for submission to Parliament. Apart from numerous assurances that matters that are the subject of uncertainty could "still be negotiated", and, in particular, the Business Unity South Africa (BUSA) "6 a side" engagement with the Department of Health, there is no opportunity for the Department to re-introduce the Bill following the outcomes of these negotiations. Unfortunately, the Bill is riddled with repetitive statements with different nuances or wording, or with serious gaps – such as mentioning any powers and functions of the plethora of structures. Most importantly, there is a constitutional issue where the State Attorney has assured the public that clause 3(4) does not affect the functions of any organ of State. This assurance is false, however, given that this is exactly what the Bill does.

The Bill also makes policy decisions. It basically instructs the executive to undertake certain delegations, set up certain structures, and amend other laws – in conjunction with this Bill to make it workable.

It also amends, so we understand, laws like the Compensation for Occupational Injuries and Disease Act,[12] the Road Accident Fund Act,[13] and the Competition Act,[14] without engagement or consultation with, or agreement from the affected departments.

Oddly, it also prescribes the selective application of the Protection of Personal Information Act.[15]

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11 Section 51 of the Basic Conditions of Employment Act (75 of 1997).
12 Compensation for Occupational Injuries and Disease Act (130 of 1993).
13 Road Accident Fund Act (56 of 1996).
14 Competition Act (89 of 1998).
15 Protection of Personal Information Act (4 of 2013).

The legal implications of, for example, the Public Service Act's[16] section 7(5) were not properly considered and allow for a transfer of an entity in contravention of section 7A of the same Act.

It repeats legal provisions unnecessarily, such as that any person can use the PAIA to access information from the Fund.

In short, the Bill is a bad summary of the NHI White Paper. It does not respect the necessary separation of powers – adherence to the *trias politica* doctrine, as part of section 1(c) of the Constitution; or the understanding of corporate governance; or the substantive principles that should underpin a funding law covering healthcare which should protect the nature of the care being bought. It also mixes the roles of the departments of health (as service providers) with that of the NHI Fund (as a purchaser of healthcare).

Where we provide detailed inputs below, this is done on the understanding that, politically, the Bill will not be withdrawn and re-submitted after the aforementioned negotiations have been completed.

4.1 General observations and inconsistencies

We are concerned that there are numerous inconsistencies contained within the Bill that effectively render many of the provisions unworkable.[17] For example, several amendments to the National Health Act[18] (NHA) should have been published in conjunction with the NHI Bill to appreciate the full magnitude of the far-reaching implications contained within the Bill. However, none of the required amendments to the NHA have been published for public commentary and the minimal amendments to the NHA found in the table in the schedule to the Bill, are not complete.

4.2 No proper impact assessment

The impact of the Bill on the provinces has also not been adequately addressed or debated. For example, provinces are constitutionally obligated to provide ambulance services, and, unless the Constitution is changed, the provincial equitable share must provide for those services. More specifically, clause 35(4)(b) states, "Public ambulance services must be reimbursed through the provincial equitable allocation". This is contradicted by clause 32(2)(a) which states, "The Fund must contract with sections within the province such as provincial tertiary, regional and *emergency medical services*" (our emphasis added).

Considering the far-reaching implications for employment and intergovernmental fiscal relations it is essential that this information is published for public debate so that a robust analysis of the Bill's extensive implications can be properly assessed.

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16 Public Service Act (103 of 1994).

17 We are grateful for the advice and inputs received from Elsabe Klinck for the information contained in the following section

18 National Health Act (61 of 2003).

4.3 Inconsistencies in the Bill

There are numerous internal inconsistencies in the Bill. Consider, for example, the implications of the removal of the Health Technology Assessment (HTA) Unit from the NHI Fund structure that was contained in the previous version of the Bill but the inexplicable retention of an interim structure on HTA in clause 57(3)(d). Clause 7(4) now only requires *a* health technology assessment. It is doubtful that this highly technical area of health economics can be undertaken by any entity without adding significant costs to health products. South Africa has a dire shortage of health economists, and then, specifically pharmaco-economic- and medical device HTA experts. This, however, becomes meaningless when one considers that the price-setting mechanisms envisaged by the Bill, and the new single exit price (SEP) for medicines that will apply to the entire health sector, will be set by a pricing committee appointed in consultation with the NHI Fund.

Clause 3(4) states that this Act does not amend any funding or functions of any organ of State. That, however, is *exactly* what the Act does. For example, by stating that it establishes a purchaser-provider split, it changes both the funding and functions of provinces, hospitals, facilities and other entities. The NHI Bill further changes what medical schemes may or may not fund, and therefore the functions of the Council of Medical Schemes, which is an organ of State. By requiring structures for service delivery, such as the Contracting Units for Primary Healthcare, it changes not only the functions of the current primary care in the public sector but also how the Health Professions Council of South Africa (HPCSA) and other statutory bodies set rules for the interaction of various professionals who are primary care providers and what they can and cannot do in terms of business models, fee sharing, and other financial interactions.

There are several other internal inconsistencies in the Bill. Consider, for example, that the Competition Act[19] is excluded (clause 3(5)), but clause 38(7) states that procurement must be in line with section 217, which requires, amongst others, that procurement must be "competitive". This leads to the question: if the Competition Act is excluded, then, according to which competition laws will this be done?

There are several clauses that envision the Minister stepping into a technical role – to make healthcare decisions – and in most of these clauses there are no criteria to delineate how those decisions must be exercised. For example, clause 7(4)(c) refers to a "complementary" Formulary "approved by the Minister", but no entity has the power anywhere else to set that "complementary" list, nor is it clear on what basis the Minister will exercise this power. Furthermore, in clause 38(4), it states that the Office of Health Products Procurement must support the Benefits Advisory Committee to develop and maintain the Formulary as well as a list of health-related products used in the delivery of healthcare services as approved by the Minister in consultation with the National Health Council and the Fund. However, any such provisions where the political functionary – the Minister – has the final say over technical matters, must include guiding criteria that constrain such discretion.

There are numerous instances where the Minister has veto powers on decisions or must be informed of decisions taken. The NHI Fund, therefore, will not be free from political interference. Some examples are provided below. The Minister will act on behalf of the funder/purchaser, in a sense becoming the *de facto* head of the NHI Fund, but also on behalf of the provider, as the political head of the national Department of

[19] Competition Act (89 of 1998).

Health, whose constitutional duties will now include actual service provision as the employer of district as well as central hospitals. Moreover, these hospitals are declared public entities. They will no longer be provincial employees. There is no other mechanism for the Fund, or the CUP, to contract with clinics or hospitals other than them being declared schedule 3B "public entities". They are currently not juristic persons. If the province is to act as an "agent", as noted in clause 32(2)(a) of the Bill, then the facilities will still fall within the province and the equitable share cannot be removed.

4.4 Benefits packages

Clause 4(1) and 7(1) provides that the "Fund, in consultation with the Minister, must purchase healthcare services, determined by the Benefits Advisory Committee, on behalf of" several beneficiary groups including citizens, residents, and refugees. This clause contains no criteria to guide the committee in making its determination, meaning that the committee can determine a package of benefits arbitrarily with no reference to the reality of the healthcare needs of society, or what good clinical practice and appropriate treatment would mean. We submit that the criteria in terms of which the health service benefits package must be set must be spelled out in the NHI Bill itself.

4.5 Registration with NHI Fund

Clause 4(4) and clause 5(1) provide that to have access to healthcare services, users must be registered with the NHI Fund. Clause 5(5) implicitly provides that applications for registration may be refused. Clause 5(8) provides that when seeking healthcare services, users "must present proof of registration" before they can access those services.

Each of these clauses are problematic because they make access to healthcare, a recognised basic human right and an entrenched constitutional right in section 27(1) of the Constitution, contingent upon having complied with a bureaucratic process of application and registration, and place part of the administrative burden on healthcare professionals, including the public sector. The most problematic element of this is that applications may be refused (not to mention delayed, as inevitably all government processes are), and that healthcare users must carry with them at all times proof of registration if they wish to use healthcare services.

The consequences of this are not only undignified, but potentially dire. What immediate recourse (other than a complicated and long process of appeal and review) do healthcare users have when their applications are refused, or if the approval of their applications are unduly delayed? What happens when healthcare users cannot find their proof of registration when they need to see a doctor? Their right to have access to healthcare is robbed from them when they are unable to present proof of registration.

There are also two further practical implications: These clauses assume (a) that all primary healthcare sites, where a person would register, have access to a computer that is able to run the NHI software and have adequate reception and internet connectivity, and (b) that there is adequate capacity to handle all registrations. For example, a general practice situated in a shopping centre in an affluent area could receive, and rightly so, applications for registration from both the employees who work in the mall, as well as from the people who live in the residential area around the mall. Who, according to what criteria, would determine the

cut-off of the adequate number of persons; what happens to persons not registered at the PHC provider of choice; and, what if, for example, residents and/or employees are not able to be assisted, even if they were registered?

We recommend that these clauses be removed from the Bill.

4.6 "Cost-effective interventions"

Clause 7(4)(b) of the Bill provides that treatment costs will not be covered if a healthcare practitioner demonstrates that "no cost-effective intervention exists for the [treatment] service as determined by a health technology assessment".

The implications of this clause are severe. Because "cost-effective" is not defined. It could be that, in the opinion of a healthcare practitioner, a treatment available for some illness is not cost-effective and thus the NHI will not fund it. For the indigent, and for those who have been deprived of their private medical scheme cover and forced onto the NHI, this could prove fatal. The lack of definition is a violation of the Rule of Law imperative that the law must be clear, and the imperative that the law must be reasonable.

Cost-effectiveness has a very specific meaning in health economics. However, when one considers the chronic shortage of skilled health economists and the lack of financial resources, it is difficult to envisage how a robust cost-effectiveness analysis will be conducted in a timely manner to make efficient and effective decisions. More importantly, there are better ways to obtain value-for-money using existing commercial arrangements that are currently utilised in healthcare systems throughout the world. Indeed, commercial companies engage with and negotiate on various cost-saving strategies for their products by incorporating trade-offs (e.g., high-volume products at low prices with niche-market products at more premium prices). Additional strategies that are commonplace offer products plus payment for, for example, companion diagnostic testing, or offer risk-sharing models, etc. All these commercial strategies that ensure business viability, will be precluded with a lowest possible price plus health technology assessment approach.

We submit that clause 7(4)(b) be excised from the Bill or that a proper definition for "cost-effective" be provided.

4.7 Independence of the Board

The memorandum to the Bill explains that the Board of the NHI Fund will be independent and "accountable to Parliament". But clause 12 provides that the Board will be "accountable to the Minister". Clause 13(1) provides that all Board members are to be appointed by the Minister, whilst, at the same time saying only one of those 11 members will represent the Minister. Even more concerning is the fact that the Board must report its decisions to the Minister and that decisions are only required to be minuted and kept for a period of three years.

It follows that the members of the Board are not independent of the Minister or government if the Board, the chairperson, and the CEO is appointed by, and can be removed by, the Minister or government. We submit that the Board must instead be chosen through a combination of appointments by Parliament and nomination

by key constituencies, like the private practitioners' profession. The NHI Fund and the Board must be accountable to Parliament as the representatives of the people in South Africa.

4.8 Freedom of choice

Clause 31(1)(a) and clause 32(1)(d) have the effect of placing the "governance and stewardship" and "planning" and "development" of the private healthcare sector under the control of the Minister and health department. This power already exists in the National Health Act – wherein it is equally problematic – making this repetition unnecessary at best, and confusing at worst. Clause 33 provides that after the NHI has been fully implemented, "medical schemes may only offer complementary cover to services not reimbursable by the Fund".

These complementary services are problematic. Which patient would, up front, know if they have an NHI-benefit condition, or a non-NHI benefit condition or a mix of NHI and non-NHI benefit conditions? It would also make it almost impossible for medical schemes to cost their plan options, as they would not know what to include in the costing and how many people might take up this cover. An additional source of concern is whether medical schemes would have the option of *not* covering a disease not covered by the NHI Fund. If not, this would leave patients without any funding options for certain conditions. The administration to separate out this restriction on the package of benefits that medical schemes may provide would be impossible to implement and people should be allowed to opt out of the NHI. These provisions have the effect of undermining South Africans' freedom of choice and right to property. South Africans should be, and constitutionally are, free to decide who to receive services from. We therefore recommend that clauses 31(1)(a), 32(1)(d), and 33 be removed from the Bill.

4.9 Needs of users

Clause 39(2)(b) provides that, in order to be accredited by the Fund, a healthcare service provider or health establishment must *inter alia* "meet the needs of users" and ensure service provider compliance with prescribed specific performance criteria. A healthcare financing entity should not be involved in accreditation or quality assessments that are already provided for elsewhere. Duplicative and overlapping jurisdictions like the kind proposed would be unlawful if introduced. The Rule of Law standard in section 1(c) of the Constitution guards against legal uncertainty and jurisdictional battles.

Furthermore, the notion of the "needs of users" is highly subjective and, presumably, highly transient. It would be absurd, in terms of clause 39(7), to allow service providers to be deprived of their accreditation because, for instance, the "needs of users" have changed and they have not adapted quickly enough. One of the benefits of the private as opposed to the public healthcare sector is competition and the pressures of market forces that result when consumers can choose which service providers they prefer. Some service providers will work differently from others. The "needs of users" will never be the same from one service provider to another and how they react to change will similarly be different. Making it a provision of law that a service provider can only be accredited and hold on to accreditation if they "meet the needs of users" is unfair, inequitable, and will lead to absurdities.

We submit that this portion of clause 39(2(b) be removed from the Bill.

4.10 Acceptable quality

Clause 39(8)(j) provides that the NHI Fund may withdraw or not renew accreditation if a service provider "delivers services of a quality not acceptable to the Fund".

This amounts to little more than formalised arbitrariness for it confers on the Fund unrestrained discretion to determine what quality is and is not acceptable. In a free healthcare market, patients and consumers decide whether the quality of care they receive is acceptable, and, if it is not, stop using those services. Government does not (and cannot) know what quality of services are best for a diverse set of 55 million South Africans.

The arbitrariness that taints this clause makes it wholly incompatible with the imperatives of the Rule of Law, and, as a result, we submit that clause 39(8)(j) be excised from the Bill.

4.11 Accreditation and code compliance

Clause 39(8)(k) provides that the NHI Fund may withdraw or not renew accreditation if a service provider "infringes any code of health related ethics or law applicable in the Republic". The problem with this provision should be self-evident. Health service providers (and all health sector businesses, such as product suppliers and private hospitals), by operation of this clause, will be forced to become party to every and any code of ethics adopted by any "health related" organisation or association, whether private or public, that decides to incorporate in South Africa. Such a requirement and the enforcement thereof not by a specific body designed for it, but by the NHI Fund, is absurd.

Moreover, it is worth noting the incompatibility between current HPCSA rules and the capitation model proposed under NHI. Capitation models pay providers a fixed monthly fee, irrespective of whether any patients are treated. However, the HPCSA ethical rules currently do not allow a service provider to receive money for services not rendered, making the proposed capitation fee structure unethical under the current HPCSA rules.

For medicines and devices and IVDs, there is a contradiction with section 18C of the Medicines Act,[20] under which marketing codes for such products must be promulgated by regulation. A similar overlap, and hence contradictory power, would exist in relation to professional statutory bodies that are "empowered" to set such codes and to "enforce" them. The NHIF should not have the power to enforce such codes or be the judge when determining whether an infringement took place.

We submit that this provision should be changed to refer only to law, and those codes of ethics the service providers by law are required to comply with.

[20] Medicines and Related Substances Act (101 of 1965).

4.12 Payment for "performance"

Clause 41(3)(b) provides that in the case of specialist and hospital services, service providers will be paid *inter alia* based on "performance".

Clause 35, however, does not recognise specialists or (private) hospitals as sellers of services for the "purchasing of health care services", neither does it recognise supplementary professionals who also work in non-primary healthcare settings. This provision is not tempered by any criteria or any definition of what "performance" means in this context.

The provision is also internally contradictory to provisions that state that the Health Care Benefits Pricing Committee will "recommend the prices" of health service benefits to the Fund (clause 26(3)); "negotiate the lowest possible prices for goods and healthcare services" (clause 11(2)(e)), or "adherence to the national pricing regimen for services delivered" (clause 39(2)(b)(vi)). Taken together, these clauses seem to suggest a pre-set system of fees and not a system of claims and reimbursement set as *ex post facto* assessments. It appears to be implied that the NHI Fund will not pay, or will pay below market price, when it is dissatisfied or otherwise unhappy with the "performance" of the service provider. It should be obvious how a provision of this nature can be abused. It is also unclear who the aggrieved party must be: The Fund or the user.

However, the more pertinent question pertains to the matter of price setting. History, and basic economics, has repeatedly demonstrated that price controls result in shortages. Government officials should not act surprised when their ill-considered policies deliver the exact consequences predicted by basic economic theory. Price controls, especially those that are fixed for protracted periods of time, will squeeze the profit margins of service providers to unsustainable levels because they prevent them from increasing prices when unavoidable input costs rise or when the economy is going through a low, no, or negative growth period.

This provision is a violation of the Rule of Law imperatives that the law must be clear and predictable. We submit that this provision must be excised from the Bill.

4.13 Power to regulate

Clause 55 is problematic *in toto*. None of the Minister's regulation-making powers are constrained by criteria, meaning the Minister can effectively rule the healthcare sector by diktat. Indeed, clause 56 talks about "Directives" which obtain the status of legislation, and even to regulations that can be made without requiring public comment periods. This violates the separation of powers and democratic principles that are part of the Rule of Law in the Constitution.

Clauses 55(1)(zA)-(zB) are especially problematic as they provide the Minister with the power to make regulations on practically any other matter not mentioned in the foregoing subclauses, without restraint. This violates the Rule of Law imperatives that the law must be predictable, that legislation which provides for discretionary powers must incorporate the criteria and for which specific purposes the powers may be exercised, and that the sole legitimate authority for making substantive law rests with the legislature and not the executive.

We submit that clause 55 be excised or be guided by criteria providing for reasonableness, rationality, effectiveness, and proportionality.

5. IS NATIONAL HEALTH INSURANCE THE APPROPRIATE VEHICLE TO ACHIEVE UNIVERSAL HEALTH COVERAGE?

The FMF supports the notion of Universal Health Coverage (UHC) and agrees that it is desirable for all South Africans to have some form of health insurance. However, we question the validity of government attempting to provide "free healthcare for all". A better aim would be to determine the best way to increase access to quality healthcare for the poor. More specifically, we believe that government should use the same framework that it applies to other constitutionally mandated objectives such as housing and education, where the State cares for the indigent and leaves the voluntary private market alone. To minimise the State's responsibility, the private sector should be deregulated while government concentrates on using scarce taxpayer resources to pay the premiums for the poor, rather than trying to insure the entire nation.

Even advanced, developed countries are struggling to meet the healthcare demands of their citizens under their "free healthcare for all" systems. Indeed, ample evidence exists of how government involvement in healthcare increases costs, erodes quality, and thwarts innovation. For example, a 2018 study entitled: *Waiting Your Turn – Wait times for health care in Canada* by the Fraser Institute found that wait times for medically necessary treatment in Canada have increased from 9.3 weeks in 1993 to 19.8 weeks in 2018. Especially long wait times were experienced for orthopaedic surgery (39.0 weeks), neurosurgery (26.3 weeks) and ophthalmology (27.5 weeks).[21]

The estimated cost of waiting for care in Canada for patients who were in the queue in 2018, according to calculations based on the methodology produced by Globerman and Hoye (1990), was an estimated CAD2.1 billion[22] (approximately R22.1 billion) – an average of about CAD1,924 (R20,295) for each of the estimated 1,082,541 Canadians waiting for treatment in 2018. Alternatively, that cost works out to roughly CAD14,573 (R153,723) per individual among the 13.2% percent of patients in the queue who were suffering considerable hardship while waiting for care. Moreover, this estimate only counts costs that are borne by the individual waiting for treatment. The costs of care provided by family members (in time spent caring for the individual waiting for treatment) and their lost productivity due to difficulty or mental anguish, are not valued in this estimate.[23]

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.[24] The Canadian single payer system is an example of what not to do in healthcare. The fact is that single payer systems are probably the worst way to achieve

[21] Fraser Institute (2018) Waiting Your Turn – Wait times for health care in Canada. Available at: https://www.fraserinstitute.org/sites/default/files/waiting-your-turn-2018

[22] CAD = Canadian dollars. On 31/12/2018 CAD1 = R10.54. Currency converter available from Bank of Canada at https://www.bankofcanada.ca/rates/exchange/currency-converter/.

[23] Fraser Institute (2019) The Private Cost of Public Queues for Medically Necessary Care, 2019 edition. Available at: https://www.fraserinstitute.org/sites/default/files/private-cost-public-queues-medically-necessary-care-2019.pdf.

[24] Chaoulli Decision (2005) https://scc-csc.lexum.com/scc-csc/scc-csc/en/item/2237/index.do.

Universal Health Coverage (UHC). 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?

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.

According to the Fraser Institute:

> "Canadians do not get good value for money from their health system. There are many hidden costs in Canadian health care that are ignored by advocates of single-payer systems. On a comparable basis, Canadians have fewer doctors and less high-tech equipment than Americans. Canadians also have older hospitals and have access to fewer advanced medicines than Americans… If Canadians had access to the same quality and quantity of health care resources that American patients enjoy, the government health insurance monopoly in Canada would cost a lot more than it currently does. Not only do Canadians have fewer health care resources than Americans, experience also shows that the Canadian health system is not financially sustainable in the long run".[25]

Canada is not the only advanced country that is struggling to meet the healthcare demands of its citizens. The British National Health Service (NHS) is often held up as an example of egalitarian healthcare, funded through general taxation and free at the point of use. However, it has demonstrated all the flaws that might be expected from a State monopoly: waste, inefficiency, under-investment, rationing and constant political interference. The result has been poor health outcomes for British citizens compared with other wealthy countries and a failure by the NHS to live up to its founding principles of comprehensive, unlimited healthcare and egalitarianism.

A headline in *The Guardian* stated, "[Britain's] NHS is in trouble and its chief executive has requested £8bn to save it".[26] Moreover, *The Guardian* states, in the NHS's efforts to cut costs "the savings have been accompanied by a substantial decline in quality – as revealed by treatment waiting time targets…there is growing evidence that, even in the parts of the country supposed to be leading the way, there are often insurmountable difficulties in trying to change the way NHS works".[27] Not surprisingly, increasing numbers are turning to private surgery because of rationing by clinical commissioning groups (CCGs) that mean people are forced to wait until they are in severe pain before being offered surgery. According to the *Telegraph*, "Since 2013, triple as many patients - some 445,000 - have had to wait more than six months for operations on their

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25 ibid

26 http://www.theguardian.com/society/2014/oct/29/how-sick-are-worlds-healthcare-systems-nhs-china-india-us-germany

27 http://www.theguardian.com/healthcare-network/2016/may/13/the-nhs-cannot-escape-its-financial-crisis-without-more-money

hips or cataracts. As a result of lengthy waiting times, companies have seen a 53 per cent rise in take-up of private operations".[28]

To correct the problems associated with government-run national health systems; the British NHS system is adopting several reforms where the private sector will play an increasing role in both financing and delivery of healthcare. In her paper entitled "NHS as State Failure: Lessons from the Reality of Nationalised Health Care", 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".[29]

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.

Evans 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".[30] 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".[31]

If advanced developed countries such as Canada and Britain, which have gross domestic products per capita that are more than three times greater than South Africa's, are struggling to meet the demands of patients under their "free health care for all" policies, it is unrealistic to assume that South Africa will be able to afford to do so. The government may be able to shift costs, but it can never avoid them. The focus should rather be on improving the quality of healthcare to the poorest people in the country, whilst not meddling with those people who are obtaining healthcare for themselves through their own resources.

Instead of concentrating power in the hands of a corrupt and inefficient State through NHI, a far more reasonable, rational and durable approach to achieving UHC would be to fix the failing public healthcare system and to expand private medical insurance so that people can gain access to quality healthcare. The proposed NHI is no elixir that will fix public healthcare by passage of legislation. A significant reason why public hospitals do not offer the same quality of care as private hospitals is because they do not have the same incentives as the private sector to modernise and maintain their facilities. In South Africa, 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

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28 Numbers going private for surgery soaring as NHS rationing deepens. Accessed: 10-10/2019. URL: https://www.telegraph.co.uk/news/2018/08/11/numbers-going-private-surgery-soaring-nhs-rationing-deepens/

29 Evans, H. (2008) NHS as State Failure: Lessons from the Reality of Nationalised Healthcare. Restricted access available at: http://onlinelibrary.wiley.com/doi/10.1111/j.1468-0270.2008.00870.x/abstract

30 ibid

31 ibid

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.

6. FINANCING OF NATIONAL HEALTH INSURANCE

We note with some concern the lack of any comprehensive costing exercise of the NHI proposal or what the impact would be on taxpayers and the economy. The revised NHI Bill that was passed by Cabinet is, however, unambiguous about the fact that South Africa's relatively small tax base will be responsible for covering whatever costs are associated with this ill-considered scheme.

This is exacerbated by an absence of any clear position on what services will be contained within the NHI benefit package and the widely publicised admission by the former Minister of Health that the 2010 cost projection of R256 billion (in 2010 prices) contained in the green and white papers was an estimation.

The green and white papers and the previous iterations of NHI policy documents have also selectively misquoted commentary by the WHO that the costs involved in achieving UHC are unimportant – and that cost consideration of NHI is "the wrong approach". The WHO is clear that costings and the associated assumptions are important in guiding policy matters and it is very clear that the NHI Bill represents a substantial change in the country's health policy.

In terms of guiding policy matters, it is also of concern that no alternatives to NHI have been proposed or costed. It remains the sole policy position of government with no consideration of alternatives, even though this policy has been on the agenda for more than 10 years.

Contradictory positions have materialised since the release of the Cabinet approved Bill on 8 August 2019. Dr Shisana, Deputy Director in the Health Department and special advisor to the President on NHI, publicly stated that NHI will require additional funding of R33 billion by 2025/26. In the same interview she stated that the NHI services would be comprehensive in nature.

The lack of certainty around these very material aspects of the NHI Bill cause concern, given the magnitude of the proposal and far-reaching implications for the private sector.

Our concerns on the cost of the NHI are summarised in the following key points:

The only official costing estimate utilised is now 9 years old – given the time elapsed and that the estimates of economic growth relied upon in both the green and white papers have not materialised, it should be discarded and replaced with an up-to-date and substantively more comprehensive costing analysis.

Alternative models should also be considered and costed.

The assumption that the current private spend by consumers on medical scheme contributions would become available for funding the NHI is unrealistic. Contributions to medical schemes and out-of-pocket spend are discretionary private spend and would not automatically become available to the NHI Fund. Effectively, the NHI will be entirely tax funded.

Understanding the cost implications of funding the NHI is a cornerstone of the entire policy. The implementation potential of NHI rests on a few key principles, of which cost to taxpayers and the economy is an indispensable attribute.

The administrative costs of NHI, including those of addressing the capacity requirements of the Office of Health Standards Compliance (OHSC), have also not been considered. Nor has there been any consideration as to whether adequate personnel with the requisite skills set exists to address the obviously greater capacity required for the OHSC under NHI.

There are three further substantive cost concerns that we would like to raise here that have not been addressed in the Bill, namely:

- The medico-legal liability facing the provincial health departments;
- The lost subsidy by the State from numerous private medical suppliers if NHI is made a complementary system; and
- The loss of VAT from private healthcare expenditure if NHI is made a Complementary system.

The combined provision for the State's medico-legal liability is an estimated R98 billion, representing 43% of the current national health budget of R226 billion for the 2019/20 financial year. The growth in this liability over the past few years has been alarming and is clearly reflective of the poor clinical audit record shown by the latest inspections of the OHSC published in 2018. This liability now represents a major impediment against expansion of future healthcare under the NHI.

There are several concerns regarding the medico-legal liability. Once the NHI is fully implemented, the question arises as to which entity will be responsible for this liability? If the liability is transferred to the NHI Fund, then this has not been accounted for in any way or means in the Bill and this large liability will clearly and materially affect the available budget for NHI healthcare services.

If the liability remains on the books of the National Treasury, then this leads to the question of whether this has been accounted for accordingly. Clearly, this liability cannot be wished away and it will be necessary to deal, not only with current cases, but also the dramatic growth in medico-legal claims witnessed in recent years.

A substantial subsidy currently exists whereby private providers delivering medicines, equipment and medical materials to the State do so via large scale tenders where prices are driven down, sometimes to below cost for the successful bidder. These bidders then supply the same materials to the private sector, at substantially higher prices, to compensate for the losses or reduced margin incurred in selling to the State.

If NHI is made a complementary system, the prices for such medicines, equipment or medical materials will increase substantially under NHI as there will no longer be a private sector subsidy to compensate for the losses or reduced margin. If the NHI Pricing Committee maintains the prices at pre-NHI levels, such providers will simply disinvest and leave NHI with even poorer services than the State is currently able to supply.

No input has been made in the Bill regarding the cost disparity between public and private providers because of VAT. Private sector providers are required to charge VAT on their services whereas public sector services do not attract VAT. How will this disparity be dealt with when contracting public and private sector providers under NHI?

Also of concern is the loss of VAT revenue for the National Treasury if NHI is made a complementary system. This has not been dealt with in the Bill. It is our view that the complete absence of quantitative and qualitative policy analysis leading to the publication of this Bill is the primary cause of so many unanswered questions on these material aspects of the viability of NHI. Our view on the overall aspect of cost is that South Africa does not have the fiscal wherewithal to fund as ambitious a policy as NHI. The green and white papers drew comparisons with other developing countries that have achieved some degree of success with national health systems (for example Thailand, Mexico, Brazil, etc) but, whilst these are also recognised as developing economies, they are fundamentally different to South Africa.

Their tax bases are orders of magnitude greater than ours and their unemployment rates are a small fraction of ours which provides these economies with a greater means to offer publicly funded healthcare. And yet, even with much greater means, countries with government operated single-payer models draw overall from several sources including co-payments, out-of-pocket payments and privately pre-funded health insurance.

These realities mean that the most effective manner for South Africa to achieve UHC is to promote an effective, efficient and expansive private sector to alleviate the burden on the State of providing the bulk of healthcare services.

Ireland, with substantially superior key economic indicators than South Africa, came to the realisation in 2015 that their country could not afford to implement their proposed Universal Healthcare Insurance model. After a costing analysis was done of the proposals contained in Ireland's 2011 White Paper, the Irish government scrapped the proposal, declaring it unaffordable.

We also have serious concerns about the impact of the NHI on the government employees' pension fund (GEPF). Public Clinics and Hospitals are not juristic persons and, therefore, cannot contract with the NHI fund. For these clinics and hospitals to contract with the NHI, they will have to become public entities, and this will happen as per the process in section 7(5) of the Public Service Act of 1994. Once they have been declared public entities, all employees will no longer be government employees, but will be employed by the entity concerned.

Currently, there are an estimated 340,000 employees in the various provincial (338,850) and national (1,616) departments of health, who would be moved to either these public entities or the NHI Fund (also a public entity). These individuals account for approximately 12.6% of all government employees (2.69 million, which includes Expanded Public Works Programme employees and municipal employees). These employees constitute 26% of active GEPF members and 19% of total Active and retired GEPF members. Considering that they will no longer be government employees, they will no longer be entitled to belong to the Government Employees Pension Fund (GEPF).

The GEPF has 1.2 million members, is managed by the PIC, and comprises 87% of all assets under management by the PIC. The PIC currently manages an estimated R2.08 trillion in assets, thus 19% of the 87% of GEPF money equates to R335 billion. The PIC would therefore have to release approximately R335 billion to the employees, or to their new pension schemes. For the PIC to release such a large sum of money, it would have to divest R335 billion to raise the required cash. This sale could either be spread out over many companies or be isolated to a few companies (with a much larger impact). This money would amount to 2.4% of the total JSE market value (R14.8 trillion) and there is no guarantee that the new funds will be invested in the same entities where the PIC held them.

We believe that to achieve effective UHC, substantial reform of the private sector and strengthening of the public sector is required. Reforms to the private sector are discussed in the next section. The challenges in the public sector are well known, *vis à vis* substantive press coverage as well as the current work undertaken by the OHSC. Suffice to say that government must be aware of what is required to undertake reform and strengthen the public sector, we do not discuss this further in this document.

7. THE ROLE OF THE PRIVATE SECTOR IN ACHIEVING UNIVERSAL HEALTH COVERAGE

The World Health Organization (WHO) defines Universal Health Coverage (UHC) as such:

> "Ensuring that all people have access to needed promotive, preventive, curative and rehabilitative health services, of sufficient quality to be effective, while also ensuring that people do not suffer financial hardship when paying for these services. Universal health coverage has therefore become a major goal for health reform in many countries and a priority objective of WHO."[32]

The WHO, however, does not prescribe how UHC is to be achieved. Indeed, the WHO director-general Tedros Adhanom Ghebreyesus states, "All roads lead to universal health coverage [but] ... countries take different paths — using either public or private providers — though public finance will always need to provide social protection for the poor, to improve equity and so no-one is left behind."[33]

The WHO recommends that countries should find ways to "pool funds … so as to spread the financial risks of illness across the population" and avoid crippling healthcare costs for both the poor and the rich. But it also stresses that nations must choose the systems that suit them best – and that whatever option is adopted must be affordable in the long-term. The WHO further categorically states, "UHC 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".[34]

While local and international endeavours have accelerated efforts towards UHC, progress towards achieving UHC is elusive, especially in lower-income countries. The HIV crisis plaguing Africa in the 1980s and 1990s

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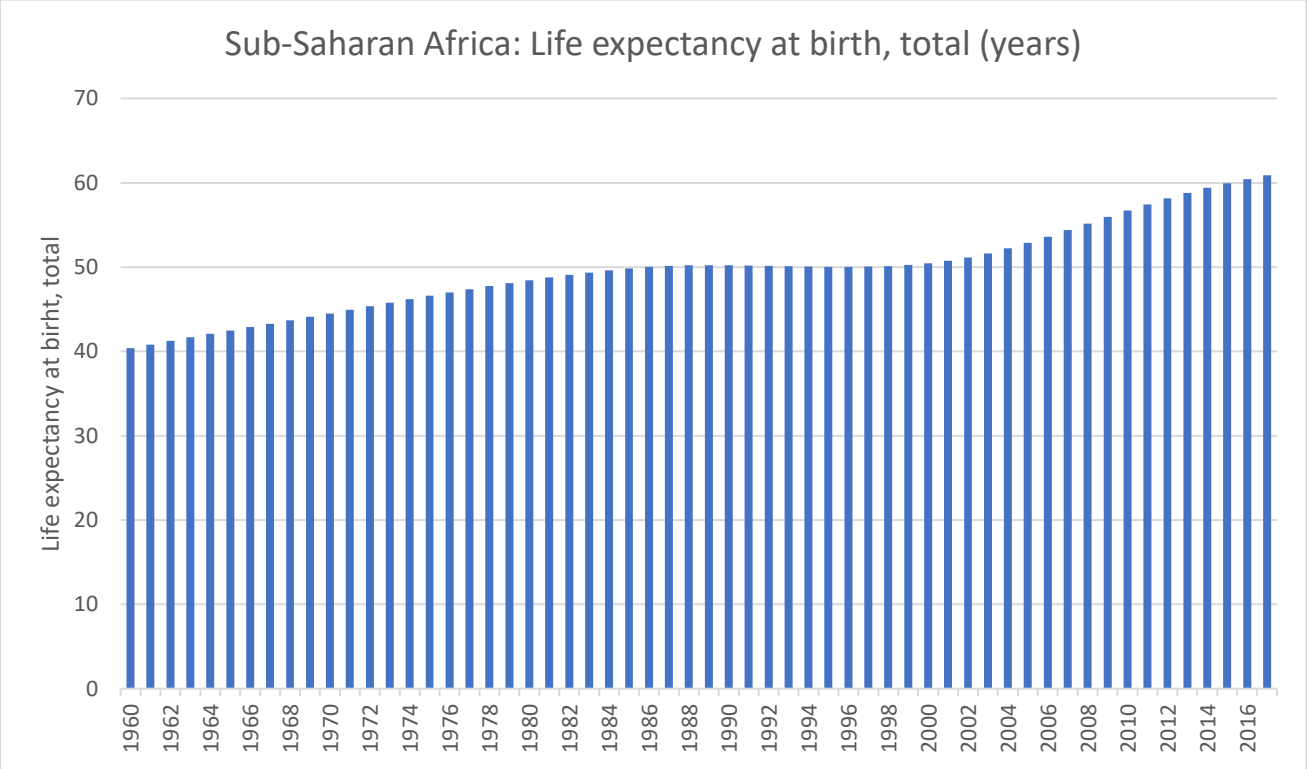
32 World Health Organization (2017). Accessed: 27-07-2017. URL: http://www.who.int/healthsystems/universal_health_coverage/en/

33 World Health Organization (2017) Accessed: 08-10-2019. URL: https://www.who.int/news-room/commentaries/detail/all-roads-lead-to-universal-health-coverage

34 World Health Organization (2017) Accessed: 27-07-2017. URL: http://www.who.int/mediacentre/factsheets/fs395/en/

reversed healthcare achievements of earlier decades, stunting advancements in key health indicators. For example, life expectancy at birth in sub-Saharan Africa (SSA), over the period 1988-1996, stagnated at approximately 49 years after registering steady improvements over the course of the previous three decades. Since the late 1990s, life expectancy at birth in SSA has improved from 50 years in 1996 to 61 years in 2017 (see Figure 1 below).



Source: World Bank, World Development Indicators

Pervasive capacity constraints within healthcare systems in lower income countries have been recognised as a significant factor hindering success towards UHC. Without a sufficiently skilled human resource base and functioning infrastructure, no amount of money can guarantee effective care.[35,36]

Global organisations such as the United Nations Children's Fund (UNICEF), the World Bank, and the Rockefeller Foundation take the view that many countries will find it difficult to achieve UHC straightaway and should instead focus on a limited set of cost-effective interventions as the first step towards achieving the goals embedded in the Alma-Ata Declaration, which seeks to protect and promote the health of all people by increasing access to Primary Health Care (PHC) services.[37] This model involves significant private-sector participation and is prevalent within resource constrained health systems.[38]

35 ibid

36 Gillam, S (2008). Is the declaration of Alma Ata still relevant to primary healthcare? BMJ 336, 536–538.

37 http://www.who.int/publications/almaata_declaration_en.pdf

38 Stuckler, D, Feigl, AB, Basu, S & McKee, M (2010). The political economy of universal health coverage, in: Background Paper for the Global Symposium on Health Systems Research. Geneva: World Health Organization.

However, there remains significant opposition to private sector involvement in healthcare, with Oxfam describing it as "unregulated, unaccountable and out of control".[39] But as Prof Dominic Montagu points out, "The idea that involving the private sector is antithetical is bizarre… more than two-thirds of all OECD countries rely mostly on private outpatient care and some of the best performing countries also deliver the majority of inpatient care through private hospitals".[40] Moreover, Prof Montagu states, "The private sector also provides up to 80% of healthcare in many developing countries".[41]

In the South African context, private health insurance provides the main vehicle for accessing private healthcare services and, given the significant amount of financial and human resources located within the private sector, the continuation and expansion of this sector is of vital importance to South Africa's overall health and welfare.

The language of section 27 is not an impediment to a private sector-led achievement of UHC, and, as alluded to above, a reading of the Constitution would seem to imply that such private sector-led development as a result of the people's exercise of their constitutional freedom, is an imperative.

8. PRIVATE MEDICAL SCHEMES AND SO-CALLED "SOCIAL SOLIDARITY"

The fundamental problem yet to be openly identified, let alone resolved, is the principle of so-called "social solidarity" contained in the Medical Schemes Act of 1998 (MSA). The MSA ushered in four main amendments: open enrolment, community rating, statutory solvency requirements, and a comprehensive package of hospital and outpatient services that all schemes are compelled to provide regardless of the individual's age, sex or health status. This minimum package of benefits is commonly referred to as prescribed minimum benefits (PMBs). Each of these amendments resulted in an increase in the cost of providing medical scheme coverage, which invariably needed to be borne by the consumer. The MSA made it compulsory for every scheme to charge the same premium to every member within an option, despite their age or state of health, a practice commonly referred to as community rating.

The MSA also introduced statutory solvency requirements, which stipulate the minimum amount of accumulated funds each scheme should hold as a reserve. Regulation 29 of the Act prescribes that the minimum accumulated funds of the medical schemes should be at least 25 per cent of gross annual contributions. This legislation was enacted to prevent a scheme from going insolvent should it experience an unusually high number of claims and record an operating loss in a particular period. But the formula for calculating the current solvency ratio was arbitrarily decided with no regard to the implications for the functioning of medical schemes. The solvency requirements were set at a level of 10 per cent when they were introduced in 2000 and have since been increased by incremental amounts to the current level of 25 per cent, which has been effective since 2004.

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39 Unregulated and unaccountable: how the private health care sector is India is putting women's lives at risk. URL https://www.oxfam.org/en/pressroom/pressreleases/2013-02-06/unregulated-and-unaccountable-how-private-health-care-sector

40 Universal health coverage and private hospitals are not mutually exclusive. URL: https://www.theguardian.com/global-development/2015/may/18/universal-health-coverage-private-sector-world-health-organisation

41 ibid

According to the Actuarial Society of South Africa, solvency is an asymptotic function of contribution increase. In other words, the higher the solvency requirement, the greater the increase required to improve solvency by 1 per cent. For example, increasing the solvency requirement from 10 per cent to 11 per cent requires a contribution increase of 1.39 per cent. However, increasing the solvency requirement from 24 per cent to 25 per cent requires an increase of 2.07 per cent in contributions. Increasing the solvency requirement drives up membership contributions disproportionately and this negatively affects the rate of increase in the number of members entering a scheme.

A scheme that has reserves below the legislated 25 per cent minimum requirement will have trouble 'catching up' because new members will be in the invidious position of having to contribute not only towards their own portion of the required reserves, but also towards making up past shortfalls, a cost for which they will receive no benefit. Despite the intentions of the South African government to prevent schemes from failing, the solvency requirements increase contributions, which, in turn adversely affect the number of individuals covered by schemes by because they artificially raise the costs of private medical scheme cover.

Under the community rating system, schemes need to attract new young members constantly to cross-subsidise the older members in the scheme. If this is not done, the average age in the pool will increase and the average premium will have to rise commensurately. The solvency ratios of schemes that are growing are placed under pressure because if a scheme's membership increases rapidly, its contribution income must rise steeply.

As noted previously, a scheme's solvency ratio is determined from the reserves as a percentage of the contributions. If the contributions increase without a similar increase in the reserves, the solvency ratio will decrease. 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. Considering South Africa's aging population and the barriers to entry in the market, the effect of introducing unrealistic statutory solvency requirements were entirely predictable – substantial consolidation of existing medical schemes. Since 2000, the number of schemes operating in the medical schemes market has dropped by over 40% from 144 in 2000, to 82 in 2016 – an average rate of decline of almost four medical schemes per year over the period.

Statutory solvency requirements introduce a considerable regulatory bias in favour of some medical schemes and against others. A scheme with accumulated reserves that exceed the required minimum is in a better position to attract new members than one with 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. This is not a desirable situation given the substantial expected future demand for healthcare in the country.

The MSA also introduced open enrolment which is the practice whereby medical schemes are compelled to accept all individuals, regardless of age, sex or health status (subject only to their income and number of dependents or both). To reduce the probability of selecting high-risk individuals, schemes were permitted to apply waiting periods and penalties to those members over a certain age joining a scheme for the first time. But this was a mere band-aid to the regulatory problem created by community rating. Finally, the MSA made

it compulsory for every scheme to provide PMBs which at an average cost of R746 per beneficiary per month in 2017, excludes a large proportion of the South African population.

The so-called act of 'social solidarity' contained in the MSA has had 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 has become progressively smaller and less healthy, driving up contribution levels and making medical scheme cover unaffordable.

In contrast, when schemes are permitted to "risk rate" individual health coverage, providers typically vary premiums based on factors associated with differences in expected healthcare costs, such as age, gender, health status, occupation, and geographic location. In cases where the individual is paying the full premium for coverage, health coverage providers will charge a higher premium to people who are older to recognise the higher expected costs. People seeking health insurance therefore pay premiums commensurate with their expected health risks.

With risk rating, the responsibility for an individual's health is placed directly in their own hands, whereas the theory of social solidarity, in practice, is neither efficient nor effective. If premiums are not varied to account for the differences in expected costs, the pool may attract a disproportionate share of older people with higher expected costs, raising the average cost and making coverage in the pool less attractive to younger and healthier people. This practice of selecting high-risk individuals is commonly referred to as adverse selection or anti-selection.

For obvious reasons, people who know that they are in poor health are more likely to seek health insurance than people in good health. A pool subject to significant adverse selection will continue to lose its healthier risks, causing its average costs to rise continually until the scheme becomes unviable and everyone in the scheme loses out – a process commonly referred to as the 'death spiral'.

The CMS Discussion Document on LCBO released in March 2019 for commentary, highlighted the fact that the percentage of beneficiaries within the medical scheme industry over the age of 50 has substantially increased from 19.8% in 2007 to 24.1% in 2017. This is a perfect example of the adverse selection outlined above.

To the extent that medical schemes are compelled to move away from economic and actuarial realities, they will be creating a situation that will be unsustainable. People, to the greatest degree possible, should be allowed to make their own decisions about their own lives and not be required to bear the costs of errors made by others. Government should not lock people into a preconceived notion of what is currently regarded as ideal. Changes will occur over time and, as the population ages, premiums will be forced to rise.

Regulatory add-ons have made healthcare much more expensive and complex than any other form of insurance. Social solidarity has caused the price of medical scheme cover and, more recently, gap cover to rise dramatically. Instead of heaping on more regulation, the obvious answer to increase the affordability and number of people covered by private medical financing arrangements would be to deregulate the market by making health "insurance" like other types of insurance.

9. THE COST IMPACT OF MEDICAL SCHEME LEGISLATION

The graph below is drawn from a study undertaken by Innovative Medicine SA (Brief 9 of 2010). It shows that there are almost 1.8 million taxpayers earning above the tax threshold who do not belong to a medical scheme.

These members are fully entitled to belong to a medical scheme and have the financial means to do so, especially the higher income bands. Considering that this graph is measuring tax payers (i.e. adults of working age), who would be supporting other dependents (minors and/or spouses), the potential membership that arguably should be in the medical scheme net, but are not, is around 4 million beneficiaries.

The current medical scheme membership is approximately 8.9 million beneficiaries, so the potential membership that is not participating, represents approximately 45 per cent of the current medical scheme membership base.

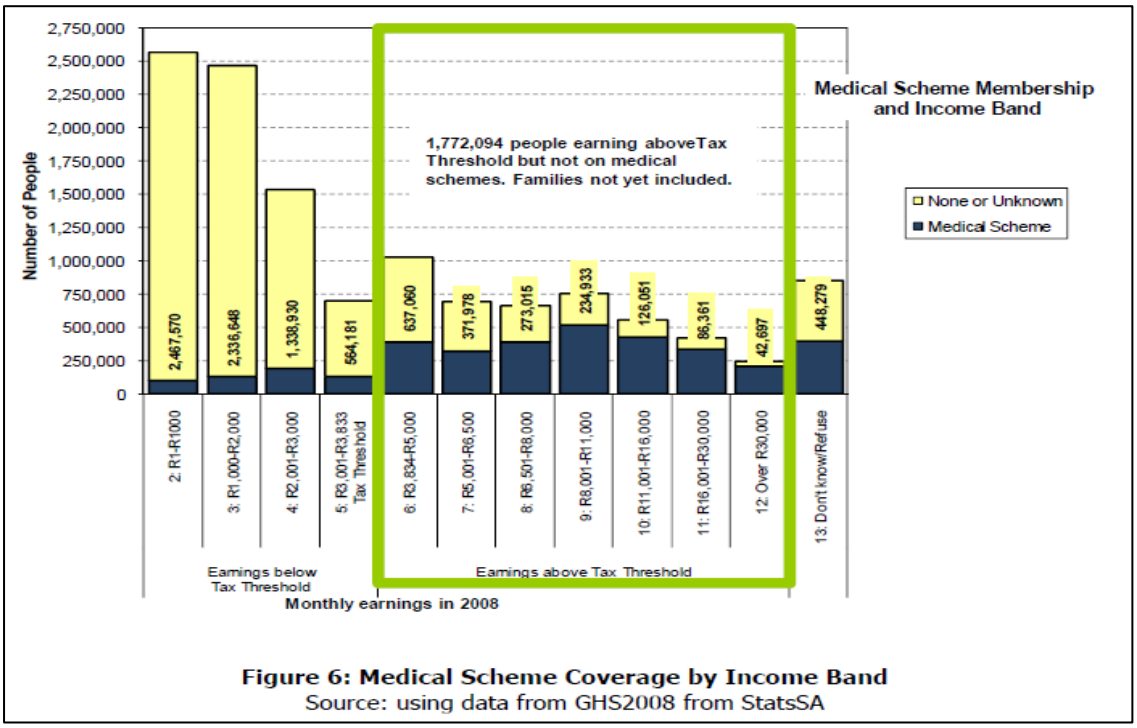
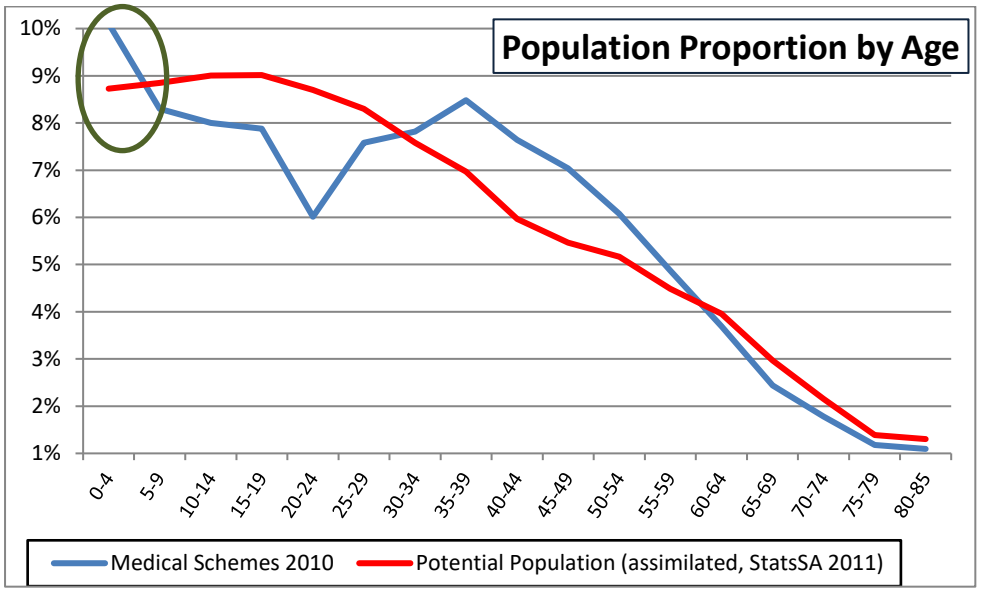


Figure 6: Medical Scheme Coverage by Income Band
Source: using data from GHS2008 from StatsSA

It is correctly assumed that members who have the financial means to belong to a medical scheme, but elect not to, are younger and/or healthier than the existing medical scheme population.

The graph below corroborates this – it compares the ***potential population*** age distribution by age band with that of the ***existing medical scheme members***.



Source: CMS Annual Report 2010 (adj to Stats SA Format); Stats SA Mid-Year Population Est (2011)

It is evident from the above graph that the existing medical membership is underrepresented in the age categories below 35 years and conversely over represented in those above 35 years.

It is also well known that age is the ***most significant driver*** of health costs, especially in tertiary services such as specialist and hospital costs. Clearly, as costs accelerate with age, it becomes too risky to remain uninsured and therefore we witness the higher than normal representation in the 35+ year age groups of medical scheme beneficiaries.

The only exception is the high risk and cost often associated with childbirth – and hence again we witness an over representation of young infants in the medical scheme population[42] in the above graph (circled in green). Young couples intending to start a family join a medical scheme knowing that they will be entitled to full benefits for the confinements within 12 months. In any event, regardless of waiting periods, a child born to a medical scheme member is entitled to immediate benefits.

Families also become selective in terms of which family members they decide to add to their medical scheme cover. There is no legal prescription to have all dependents in a family on cover. Families can leave off their younger, healthier children or choose only to cover the member with a serious health condition.

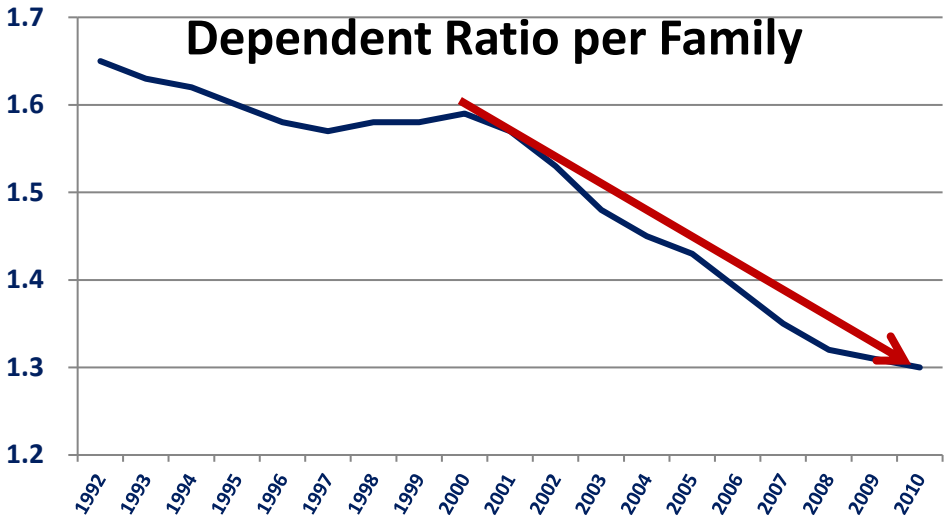
It is apparent to see the substantial reduction in family size since the introduction of the MSA in 2000.

This type of human behaviour represents classic examples of the opportunistic behaviour by consumers ('adverse selection' or 'anti-selection'). Anti-selection has become widespread in the industry and is given legitimacy by the unfortunately skewed policy framework that underpins the MSA.

[42] CMS data shows age categories of younger than 1 year and then from 1 to 4 years. However, StatsSA data only provides a category from 0 – 4 years so no direct comparison is possible for infants younger than 1 year.

An actuarial study conducted by experienced healthcare actuary, Barry Childs (Lighthouse Actuarial, 2013), estimated that the impact of maintaining open enrolment and community rating without a concomitant balancing of these risks with mandatory participation, has raised claims costs in the private sector by 30 to 35 per cent.

We submit that the regulatory framework created by government for medical schemes to operate in for the past 19 years is one of the main driving factors that has artificially raised the price of private healthcare in South Africa. Yet these high costs are now being used to justify the introduction of the government's NHI scheme. We submit that government cannot justify NHI on the basis of a fact (i.e. high costs) for which its own regulatory framework is largely responsible in causing.



The lack of appropriate regulation of the private sector has also been raised in the final findings of the Competition Commission's Health Market Inquiry (HMI) published on 30 September 2019.[43] The appropriate action, as also recommended by the HMI, would be to rectify the regulatory framework for the private market – not eradicate the market altogether, as the NHI Bill clearly intends to do.

10. ALTERNATIVE SOLUTIONS TO THE PROPOSED NHI SCHEME

Most, if not all, developing countries face the challenge of having insufficient revenues to adequately provide for the healthcare needs and demands of their populations. Bowie and Adams from the Wharton Business School state, "In the majority of low and middle-income countries, the government cannot raise enough funds through general taxation to adequately finance the public health system and lack the institutional and organisational capacity to establish a functioning system of mandatory health insurance for the formally employed".[44]

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43 Justice Sandile Ngcobo. Presentation of the HMI Provisional Report. Accessed 20-09-2018. Available at: http://www.compcom.co.za/wp-content/uploads/2018/07/Panel-Chair-Former-Chief-Justice-Sandile-Ngcobo.pdf

44 Bowie, R and Adams, G (2005) Financial and Management Practice in a Voluntary Medical Insurance Company in the Developed World, background paper for Conference on Private Health Insurance in Developing Countries, Wharton Business School.

Given South Africa's narrow tax base, high disease burden, and limited resources, how should the government proceed with its healthcare reform? Alexander Preker, who was previously the lead economist at the World Bank, provides part of the solution. He states, "The ability and willingness of households in developing countries to pay for health care is far greater than the capacity of government to mobilise resources through taxation".[45] One would imagine that regular, small, fixed payments to a form of private health insurance would make intuitive sense – as opposed to the rare but devastatingly high out-of-pocket payments required when illness strikes.

Private health insurance increases access to quality care and improves consumer choice, leading to greater health system responsiveness. If given the option, the vast majority of South Africans would choose to go to a private healthcare facility. Indeed, a significant amount of out-of-pocket healthcare expenditure is already undertaken to access private healthcare and, as incomes improve, we can expect more people to join private medical scheme arrangements.

Expanding the private health insurance sector will provide consumers with greater choice and satisfaction. However, the biggest obstacles preventing medical schemes from rolling out options for low-income individuals are the regulations put in place by government. To the extent that medical schemes are compelled to move away from economic and actuarial realities, government will be creating a situation that is unsustainable. People, to the greatest degree possible, should be allowed to make their own decisions about their own lives and not be required to bear the costs of errors made by others. More specifically, government should not lock people into a preconceived notion of what it currently regards as ideal.

If government views "health care for all" to be politically essential, it could require the population to privately and individually purchase mandatory cover from privately competing insurers and medical schemes to insure against catastrophic, health-related events, but otherwise leave them alone to provide for their own and their families' medical-related and other needs. Moreover, 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 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 will thrive and ensure that the best service for the best price is given.

Government should concentrate its efforts and scarce taxpayer resources on those who cannot afford healthcare. For these individuals, government could act as financier and let people decide for themselves where to spend their money – it is not necessary to finance the healthcare needs of the *entire* population. Doing so is not a particularly good use of scarce taxpayer resources. Spending in one area of the economy necessarily comes at the expense of other areas. If government decides to dedicate more of the budget towards healthcare, it will mean less money available for such essential services as education, policing etc.

[45] Preker, A (2004) Voluntary Health Insurance in Development: Review of role in African region and other selected developing country experiences, World Bank.

To fulfil the task of acting as financier for the poorest of the poor, government can and should enlist the support and help of the private sector by contracting out those services that can be provided more efficiently by private providers and administrators. 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 Bill is thick on populist rhetoric and thin on critical details to make an informed decision on the health and economic impacts of the proposal. South Africa is facing an important tipping point that affects not only each one of us but also our children and grandchildren and generations to come. We can either choose systematic deregulation of the private sector on both the funding and provision sides, or we can choose even tighter controls where all our healthcare decisions are governed from the cradle to the grave. We need to have the courage to recognise the impending disaster and correct the mistakes before they are made.

If South Africans want better health outcomes, then we should be focussing on the institutions that we know result in higher levels of economic growth. The South African government's NHI is premised on a principle of compulsion – an anathema to personal and economic freedom. It is only with economic growth and increased incomes that South Africans will gain greater access to medicines and hospital services. Government, therefore, should focus on adopting policies that foster economic growth.

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