



An Overview of South Africa's Health Assets and the National Health Insurance Policy

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Abbreviations:

AIDS	- Acquired Immune Deficiency Syndrome
ANC	- African National Congress
ART	- Anti-Retroviral Treatment
CEO	- Chief Executive Officer
CMS	- Council for Medical Schemes
CPI	- Consumer Price Index
CSPM	- Complementary Single-Payer Model
DHA	- District Health Authority
DPME	- Department of Planning, Monitoring and Evaluation
DoH	- Department of Health
GDP	- Gross Domestic Product
GHS	- General Household Survey
HIV	- Human Immunodeficiency Virus
HMI	- Health Market Inquiry
ICU	- Intensive Care Unit
LCBO	- Low Cost Benefit Option
MAC	- Ministerial Advisory Committee
MEC	- Member of Executive Committee
MoH	- Minister of Health
MSA	- Medical Schemes Act
NHI	- National Health Insurance
NHIF	- National Health Insurance Fund
NHS	- National Health Service
NT	- National Treasury
OHSC	- Office of Health Standards Compliance
PEPFAR	- US Presidential Emergency Plan for AIDS Relief
PLHIV	- People Living with HIV
PPE	- Personal Protection Equipment
RAM	- Risk Adjustment Mechanism
REF	- Risk Equalisation Fund
SA	- South Africa
SEIA	- Socio-Economic Impact Assessment
SOE	- State-Owned Enterprise
TB	- Tuberculosis
UHC	- Universal Health Coverage
UMIC	- Upper Middle Income Countries
VAT	- Value Added Tax
WHO	- World Health Organisation

1. Overview

The National Health Insurance (NHI) proposal represents the largest potential reorganisation of any sector of the economy in South Africa's history.

While it remains a laudable goal that there should be better quality and more readily accessible healthcare, we do not believe that the NHI proposal represents a reasonable option to achieve it or that a sufficient level of technical analysis has been performed by the Department of Health (DoH) during the policy process in fully understanding the complex dynamics of either the public or private sector.

Even a cursory view of varying national health systems globally clearly shows that there are few systems that are structurally comparable but the overriding commonalities observable in virtually every country is that health systems are complex and require the concerted efforts of functioning and efficient public and private sectors, with a variety of funding sources, to achieve the overarching goal of quality universal health coverage.

We intentionally use the term 'quality universal health coverage' above, since much confusion has been sewn into this policy process arguing that the NHI is necessary for South Africa to achieve universal health coverage. As has been corroborated by several studies, and we will discuss later in this report, South Africa does currently achieve near universal health coverage (UHC).

South Africa possesses two substantial health assets in the public and private sectors, and when undertaking a fact based assessment of what the problems are within them, such as this report aims to do, it becomes clear that there are two main problems.

What afflicts the public health sector is poor quality of care – not a lack of universal access. Quality care is available in the private health sector, but the sector is inefficient and expensive, thereby reducing its accessibility through affordability constraints.

The policy process that has characterised the NHI proposal is one in which the above factual problems ailing each sector have been supplanted with politically motivated statements declaring that SA does not have UHC and that a lack of funding - specifically under government control - is the singular problem preventing the country from achieving it.

In Section 2 of this document, we will show how public health expenditure has grown substantially over the past two decades - both in per capita and in real terms - and the ratio of public medical personnel to citizens has also improved substantially over the same period.

Instead of addressing the poor levels of quality in the public sector, this matter has been deftly deflected by politicians and policymakers into divisive, racialised and politically charged declarations to the effect that the unequalness of our society and a lack of funding are the causes of public sector woes.

The high cost of the private sector has also been criticised by government officials as being causal of public sector failings, even though the Health Market Inquiry's six-year long assessment of the private sector found that much of the private sector's failings were a result of an incomplete regulatory framework and inadequate regulatory oversight from government and regulators.

It is self-evident that if the problem statement in any policy process lacks credibility or coherency, we need to delve further in analysing the existing problems, assess what path the policy process has taken and propose better alternatives.

We suggest a better alternative policy process, as opposed to defined solutions, because it underpins our view that no substantive reorganisation of such a large segment of the economy can be done in isolation, without qualitative and quantitative engagement with all stakeholders and robust technical analyses to inform and guide workable solutions during the policy process.

From the outset of the NHI policy process in 2009, the NHI was the solution that had already been decided upon, with the subsequent policy process lacking coherency in order that *'facts'* should fit in with a predetermined NHI narrative.

The policy process has further been characterised by a dearth of technical policy work and a lack of adequate engagement with affected stakeholders.

This document serves to provide a contextual background of the country's substantial health assets and the inadequate policy process that the NHI has followed, with a view to raising awareness on the treacherous path down which this policy will lead us.

2. Public Health System

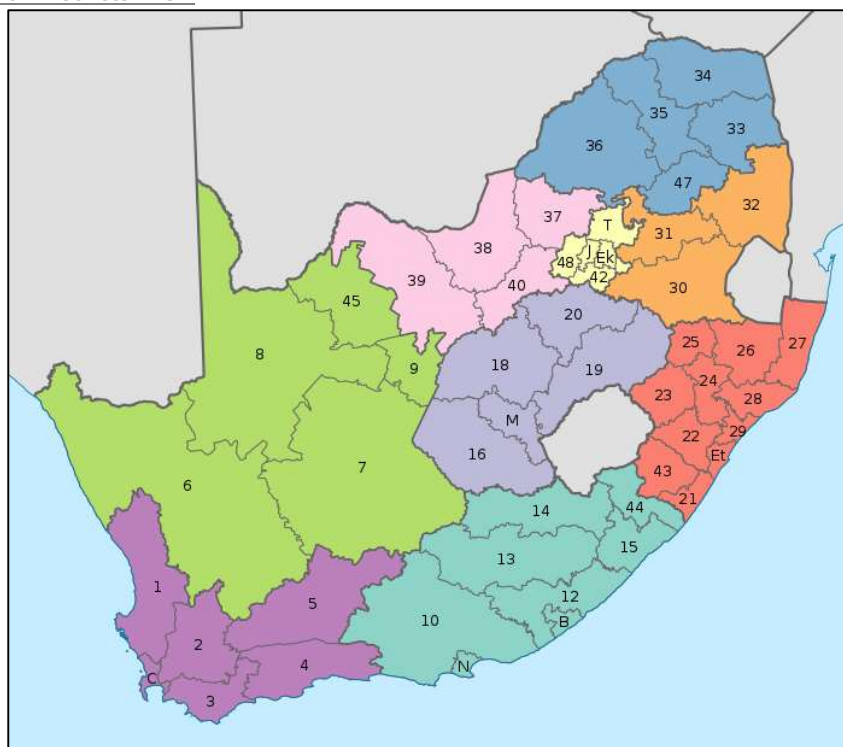
2.1. Expenditure Overview

2.1.1. Historical Expenditure

South Africa's public health system constitutes a national Department of Health (DoH) with nine provincial departments thereunder, collectively divided into more than 50 health districts.

The national budget from National Treasury (NT) passes to the NDoH, whereafter it devolves to the provinces via the provincial equitable share and conditional grants.

Health Districts in SA



A study¹ undertaken by National Treasury in 2017, reflecting on public health expenditure as far back as 1995/96, shows that there has been a consistent trend in expenditure rising, in real and per capita terms, since 2001. It showed that from 2001 to 2016, in real terms, national health expenditure rose by 136% and when also factoring in the population growth of uninsured citizens, the real and per capita health expenditure increased by 94%.

Table 1² below shows figures over a shorter time period (2010 to 2020) and also how this expenditure has changed in real terms and per capita³ terms over this decade.

¹ SA Health Review 2017: Blecher, et al

² SA Health Review, 2019 (Day, et al) & Treasury Budget Review 2019/20

³ Measured against the uninsured population (citizens not on medical scheme cover)

In real terms, provincial expenditure increased by 50.8% from 2010 to 2020 and after factoring in the uninsured population growth over the same period (i.e. real per capita expenditure), it increased by 28.2% over the same period.

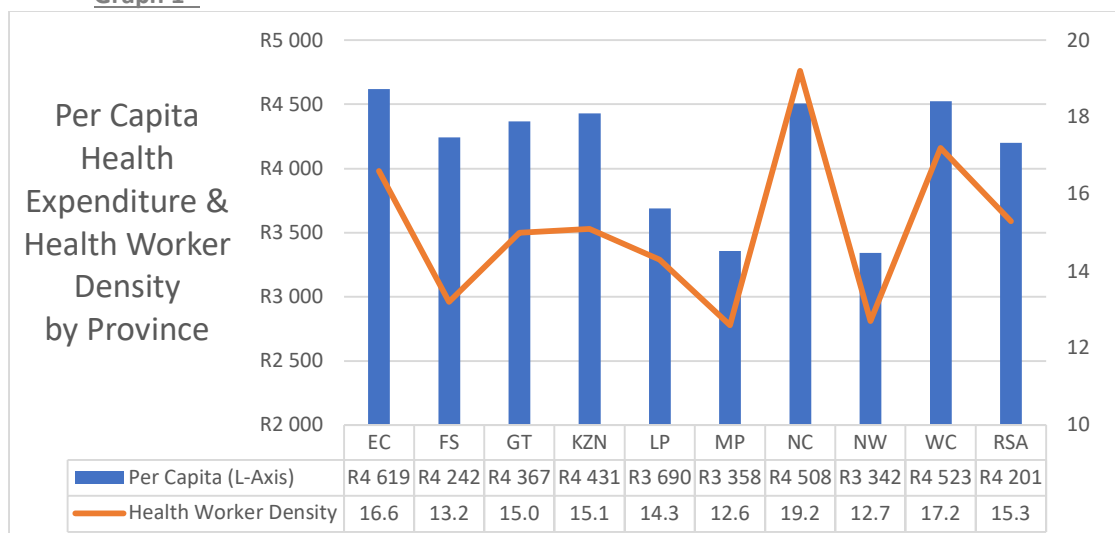
Table 1 (price in 2009/10)

Year	Total Provincial Expenditure Nominal (Rm)	Total Real ⁴ Expenditure (2009/10 price) (Rm)	Uninsured Population ('000) ⁵	Per Capita Expenditure in Real ³ Terms (2009/10 price)
2009/10	91 952	91 952	42 904	R2 143
2010/11	100 759	96 146	43 474	R2 212
2011/12	113 989	103 267	44 151	R2 339
2012/13	125 473	107 705	44 936	R2 397
2013/14	133 581	108 056	45 764	R2 361
2014/15	144 283	111 841	46 614	R2 399
2015/16	158 903	115 798	47 362	R2 445
2016/17	170 171	118 010	48 160	R2 450
2017/18	185 013	122 987	48 863	R2 517
2018/19	202 744	129 701	49 570	R2 617
2019/20	216 791	138 687	50 471	R2 748
Growth in Real Terms (2019/20 vs 2009/10)		50.8%	17.6%	28.2%

Factually, there has been a very substantial improvement in public sector expenditure levels for the past two decades, even after factoring in inflation and the population growth of uninsured citizens. We will discuss this later in Section 4, where we show that throughout the NHI policy process, it has been inaccurately claimed that public sector health budgets have been declining in real terms.

Graph 1 below shows the 2018/19 per capita public provincial expenditures by province⁵, using uninsured population figures.

Graph 1⁶



⁴ Statistics South Africa Consumer Price Index (P0141) May 2021

⁵ Statistics South Africa (Stats SA) mid-year population estimates and Council for Medical Schemes annual reports

⁶ SA Health Review 2019: Day, et al

The Eastern Cape has the highest annual expenditure, at R4,619 per person, and North West has the lowest at R3,342 per person.

Later, in Section 2.5, we will show that the Eastern Cape has the highest medical malpractice liability of all the provinces, both in nominal and per capita terms, yet it receives the highest per capita budget in the country along with having the 3rd highest provincial health worker density.

The Eastern Cape also has the 2nd highest hospital bed density ratio of all the provinces (20.6 per 10,000 uninsured population – see Section 2.3).

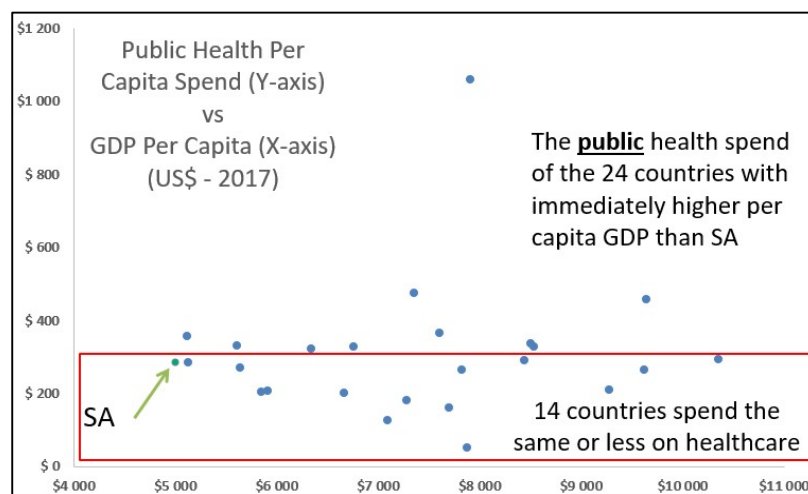
This is starkly contrasted against the Western Cape which has a similar per capita budget and health worker density and hospital bed density levels, yet it is facing virtually negligent levels of medical malpractice claims.

2.1.2. Public Sector Expenditure Comparison Internationally

Graph 2 below shows a comparison of total per capita⁷ public health expenditure against 24 countries. These countries were chosen by doubling SA's per capita GDP and then selecting all the countries from South Africa, as the base country, up to the country with a per capita GDP closest to double that of South Africa's GDP.

So, in this cohort of 25 countries⁸, South Africa has the lowest per capita GDP.

Graph 2 (Prices in US dollars, 2017 values)



Of the 24 wealthier countries, 14 spend the same or less on public healthcare on a per capita basis, with 8 spending significantly less. Only three of the 24 countries spend significantly more than SA.

Graph 3 compares the health expenditure of the same countries against their under-5 mortality⁹ rates.

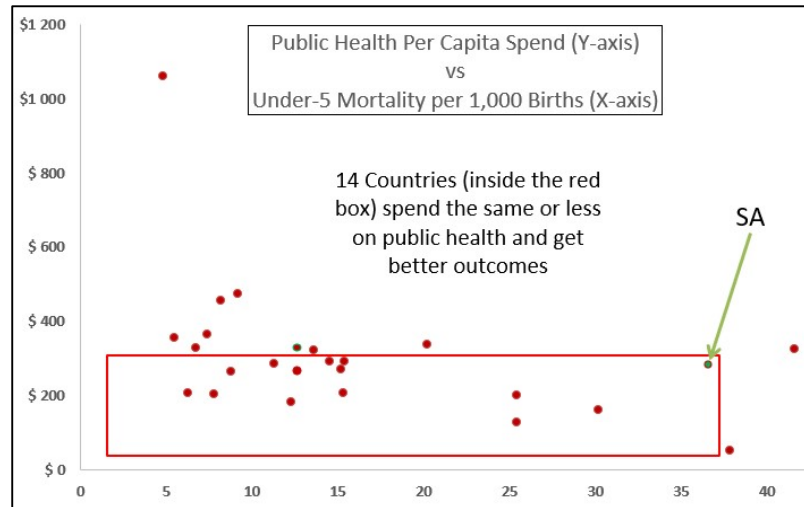
⁷ Total public health expenditure across total population (source: Institute of Health Metrics and Evaluation, 2017)

⁸ Turkey, Romania, Mauritius, Malaysia, Russia, Brazil, Mexico, Cuba, Equatorial Guinea, China, Gabon, Bulgaria, Lebanon, Kazakhstan, Turkmenistan, Botswana, Dominican Republic, Libya, Peru, Thailand, Ecuador, Colombia, Iran, Bosnia/Herzegovina (source: UN/IMF)

⁹ Institute of Health Metrics & Evaluation, 2017

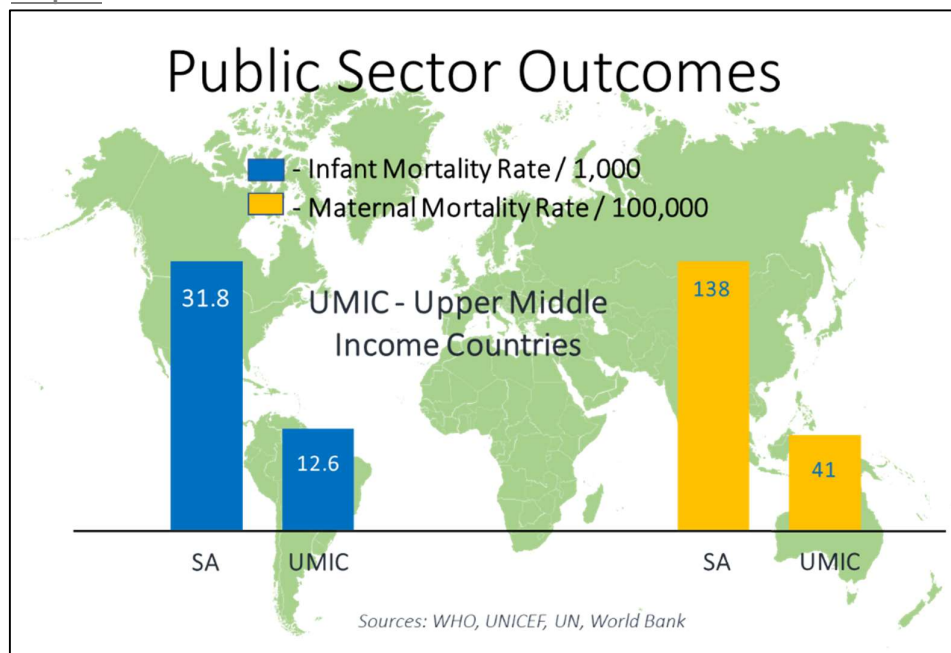
SA performs poorly against its peers, with 13 countries spending similar or less on healthcare, with 10 of the 13 achieving significantly better under-5 mortality rates. Only one country with a similar per capita spend on health has a higher mortality rate - Botswana (41.6).

Graph 3 (Prices in US dollars, 2017 values)



Other universal measures of the quality of a country's health outcomes are infant (< 1 year) and maternal mortality rates (< 42 days from birth). Graph 4 below shows how South Africa compares on both these measures against the averages for Upper Middle Income Countries (UMIC).

Graph 4



From this section we can conclude the following:

- Public sector health expenditure has been growing substantially in both real terms and per capita terms for the past two decades.
- In comparison to 24 richer peer countries, SA's per capita public health expenditure is proportionally high, ranking the 14th highest out of the 25 countries, with only three of the 24 countries spending significantly more than South Africa.
- In terms of under-5 mortality, South Africa performs poorly with the 3rd worst under-5 mortality in the grouping, despite having higher than average expenditure.
- On comparison of infant and maternal mortality rates with the average rates of other Upper Middle Income Countries, SA also performs poorly.

Note: The outlier country in Graphs 2 and 3 above on public health expenditure is Cuba, which has nationalised all healthcare funding and provision.

National health expenditure is very high at **13.4%*** of GDP, more than double the 2nd highest expenditure in the above country grouping. Yet Cuba's under-5 mortality rate is only marginally better than the cluster of countries in the bottom left of Graph 3 and equal to at least one in that cluster.

(* - Source: Institute of Health Metrics and Evaluation, 2017)

The NHI proposal has been largely modelled on the nationalised Cuban health system and while it does achieve good health outcomes relative to SA, when also factoring in cost and health burden, it performs less well. Countries with similar health burdens to Cuba are able to achieve similar health outcomes at substantially lower costs.

This is made even worse when considering that Cuba pays its doctors extremely low salaries[#], so if these were more in line with international norms, Cuba's national health expenditure would be even higher.

([#] - An Evaluation of Four Decades of Cuban Healthcare, Felipe Eduardo Sixto, 2002)

This reflects the inefficiency of nationalised monopoly systems, such as what the NHI proposal is.

We will elaborate later how the monopoly nature of such health systems achieve the opposite of what they intend, namely high and growing costs, relatively poor outcomes and lengthy waiting times for care.

2.2. HIV/AIDS

There are only three countries in Graphs 2 and 3 above that have significant rates of HIV infection - Botswana, South Africa, and Equatorial Guinea (22.8%, 17.8% and 5.3% respectively for ages 14 to 49)¹⁰. Table 2 below shows the countries with the top 20 highest HIV infection rates globally, listed from highest to lowest.

While some countries like Zimbabwe and Botswana have made positive impacts on infections rates over the past 20 years¹¹, South Africa¹² continued to experience significant increases over this time.

Table 2 – (All health data derived from the Institute of Health Evaluation and Metrics, 2017 - <http://www.healthdata.org/>)

Country	HIV Prevalence (14-49)	GDP Per capita (US\$) (UN Data 2017)	Public Health Expenditure Per Capita pa (US\$ - 2017)	Under-5 Mortality (per 1,000 births)	Life Expectancy (F)	Life Expectancy (M)
Eswatini	27.2%	\$3 339	\$129	47.6	65.1	54.9
Lesotho	23.7%	\$1 067	\$69	64.6	59.3	50.3
Botswana	22.8%	\$6 768	\$326	41.6	71.0	67.0
South Africa	17.8%	\$5 045	\$284	36.6	69.7	62.8
Namibia	13.5%	\$4 379	\$241	35.0	70.7	62.3
Zimbabwe	13.5%	\$1 101	\$31	52.6	64.4	58.1
Mozambique	11.9%	\$371	\$8	68.0	62.0	54.8
Zambia	10.8%	\$1 157	\$23	51.1	66.3	60.4
Malawi	8.8%	\$289	\$11	58.4	66.9	59.6
Kenya	5.6%	\$1 405	\$38	39.7	68.8	63.2
Uganda	5.5%	\$611	\$7	57.5	69.2	62.3
Equatorial Guinea	5.3%	\$8 214	\$52	37.8	66.4	64.3
Tanzania	3.9%	\$1 076	\$15	56.5	68.9	64.6
Cameroon	3.5%	\$1 107	\$8	70.9	65.1	61.0
Gabon	3.4%	\$6 602	\$160	30.2	72.1	65.1
Guinea-Bissau	3.3%	\$591	\$4	70.6	62.6	57.4
Central African Rep.	3.2%	\$342	\$3	121.3	54.9	49.1
Rwanda	2.6%	\$673	\$16	46.2	70.8	65.8
South Sudan	1.3%	\$703	\$3	91.0	61.8	56.9
DR Congo	0.7%	\$460	\$2	57.4	64.3	60.4

■ - Under 5 mortality rates > 50/1,000 ■ - Under 5 mortality rates < 50/1,000

High HIV infection rates are correlated with poorer health outcomes, whereas higher per capita expenditures are inversely correlated. Table 3 shows a comparison between two groups of three countries each from Table 2, each group with relatively high and, conversely, low infection rates and expenditures:

Table 3 (unweighted averages)

Group #	Country Grouping	Average HIV Prevalence (14-49)	Average Public Expenditure Per Capita (US\$ - 2017)	Average Under-5 Mortality (per 1,000 births)
1	High - Botswana, Namibia & SA	18.0%	\$283	37.7
2	Low - Kenya, Equatorial Guinea & Gabon	4.8%	\$83	35.9

¹⁰ Institute of Health Metrics & Evaluation, 2017

¹¹ Zimbabwe and Botswana's HIV infection rates (in ages 14-49) in 2000 were 22.9% and 26.1% respectively (source: statista.com)

¹² South Africa's HIV infection rate (in ages 14-49) in 2000 was 12.6% (source: statista.com)

Group 1 (high) has public per capita expenditure and HIV infection rates that are 3.4 times and 3.7 times higher respectively than Group 2 (low), yet both groups achieve similar 5-year mortality rates.

This strongly indicates that the strategy of *reducing the HIV infection rate* is much more cost effective in achieving improved outcomes than applying greater resources to treatment.

It is clear that South Africa's persistently high and growing HIV infection rate is weighing down the public sector's ability to improve health outcomes, despite having the relatively high and growing per capita public sector expenditure outlined in Section 2.1 above. As can be seen from Table 2 above, there is no international example of a country with a high HIV infection rate and a significantly higher health budget than SA. The only country in Table 2 with a higher per capita health budget than SA is Botswana, but its under-5 mortality rate is equally poor.

South Africa is falling behind in the fight against HIV, with the infection rate having steadily climbed over the past two decades. Table 4 shows the 2019 estimates of citizens infected, with status known, on treatment and virally suppressed in South Africa. It is acknowledged that South Africa does have the largest HIV management programme in the world, but we still only record treatment levels for PLHIV¹³ at around 63%, despite estimates that 88.5% of PLHIV know their status.

Table 4¹⁴

HIV Infection 2019	Total Infections	Positive Status Known	On Treatment	Virally Suppressed
Number	7 500 903	6 637 000	4 744 021	2 947 582
% of Total Population	12.8%	11.3%	8.1%	5.0%
% of Total Infected	100.0%	88.5%	63.2%	39.3%

A study published in SA Health Review 2019¹⁵ indicated that total public spend on HIV and TB (R28.8bn in 2016/17) is heavily reliant on international aid organisations, with 24% of the spend originating there, most notably from PEPFAR¹⁶ (21%). The authors concluded as follows:

"HIV and TB budget allocations are expected to grow in the future, despite the fiscal constraints in the country. However, the challenge remains to reduce new HIV infections, which continue to put pressure on the government's overall response and financing of HIV and TB. Although ART contributes to reduced HIV infection rates, major prevention efforts are still required, and these are among the HIV interventions currently most dependent on donor funding."

PEPFAR's funding requirements are heavily reliant on achieving preventative targets and will likely be revoked if these targets are not achieved. Given the pressures that the economy faces post the Covid-19 pandemic, it is also likely that budget allocations will experience significant strain, as they already did in the most recent 2021/22 health budget allocations¹⁷.

A greater focus on more effective HIV prevention programmes from government is becoming critical, as it is self-evident that a reduction in infection rates will not only retain much needed donor funding but also reduce treatment costs, improve labour force productivity and improve allocations to other health services.

¹³ People Living with HIV

¹⁴ Health and Related Indicators, 2019 (Candy Day, et al. Health Systems Trust)

¹⁵ A review of health, HIV and TB resource allocation and utilisation in South Africa, 2013/14 - 2020/21

¹⁶ US Presidential Emergency Plan for AIDS Relief

¹⁷ <http://www.treasury.gov.za/documents/national%20budget/2021/ene/Vote%2018%20Health.pdf>

2.3. Public Sector Resources

In Table 5 below we show the number of filled clinical posts in the public sector from 2006 to 2016.

Correlating to the real per capita increase in expenditure outlined in Section 2.1, the number of filled clinical posts increased substantially by 42.8% from 139,769 to 199,640 over this period.

Table 5 – Filled Posts in Departments of Health¹⁸

Occupational Classification (as of March, each year)	2006	2008	2012	2016	Posts per 1,000 Citizens ¹⁹		2006 to 2016 (%)
					2006	2016	
Professional Nurses	44 245	47 975	58 274	66 024	1.07	1.39	+30%
Nursing Assistants	31 923	34 082	35 377	32 843	0.77	0.69	-10%
Staff Nurses and Pupil Nurses	20 866	22 781	29 353	30 774	0.50	0.65	+29%
Medical Practitioners	9 603	10 781	13 204	14 545	0.23	0.31	+32%
Ambulance & Related Workers	7 672	10 304	11 308	12 361	0.19	0.26	+41%
Student Nurses	8 944	9 789	10 816	6 911	0.22	0.15	-33%
Medical Specialists	3 711	4 050	5 198	4 990	0.09	0.11	+17%
Radiographers	2 109	2 155	4 714	4 973	0.05	0.11	+106%
Pharmacists	1 755	2 157	3 710	4 874	0.04	0.10	+143%
Health Sciences	2 388	4 423	4 247	3 751	0.06	0.08	+37%
Optometrists	52	33	2 310	2 445	0.00	0.05	+4006%
Emergency Services	168	611	2 240	2 360	0.00	0.05	+1127%
Medical Research	80	69	2 076	1 731	0.00	0.04	+1790%
Pharmaceutical Assistants	409	648	1 439	1 723	0.01	0.04	+268%
Physiotherapists	790	908	1 069	1 306	0.02	0.03	+44%
Dieticians and Nutritionists	515	612	940	1 253	0.01	0.03	+112%
Occupational Therapists	672	789	1 020	1 251	0.02	0.03	+63%
Dental Practitioners	719	655	997	1 143	0.02	0.02	+39%
Supplementary Radiographers	186	180	904	982	0.00	0.02	+361%
Psychologists & Counsellors	406	441	669	774	0.01	0.02	+66%
Speech Therapy & Audiology	283	337	491	702	0.01	0.01	+117%
Medical Technicians	819	413	464	515	0.02	0.01	-45%
Environmental Health	883	820	902	442	0.02	0.01	-56%
Oral Hygienists	143	159	308	336	0.00	0.01	+105%
Dental Therapists	147	146	259	318	0.00	0.01	+89%
Dental Specialists	41	32	143	173	0.00	0.00	+269%
Community Development Workers	202	164	96	95	0.00	0.00	-59%
Dental Technicians	38	39	42	45	0.00	0.00	+3%
Total Clinical Posts	139 769	155 553	192 570	199 640	3.38	4.22	+25%
Total Non-Clinical Posts	94 411	106 298	122 289	109 746	2.28	2.32	+1.5%
Total Posts	234 180	261 851	314 859	309 386	5.66	6.53	+15%

Measured on a per capita basis, the overall ratio of medical personnel per uninsured citizen improved by 25% between 2006 and 2016.

Only 5 of the 28 clinical categories above declined in per capita ratios between 2006 and 2016.

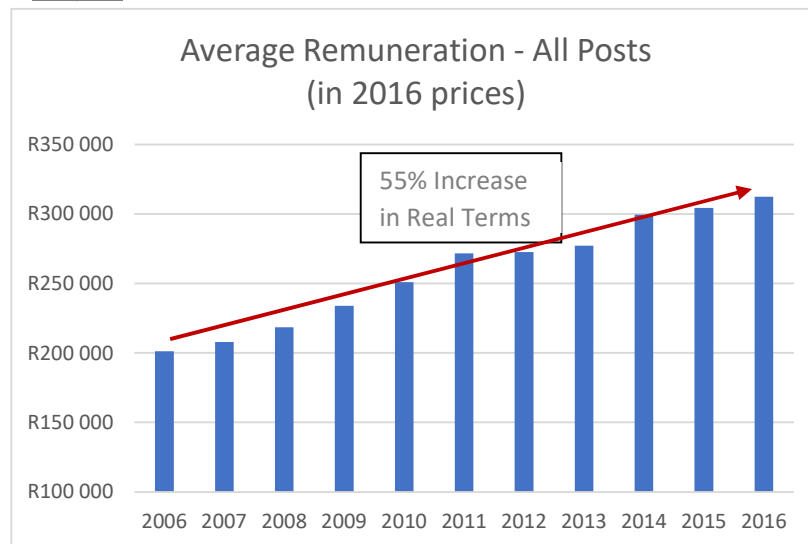
¹⁸ National Treasury, Vulindlela [1 December 2016]

¹⁹ Number of Filled Medical Posts (Medical Providers) per 1,000 uninsured citizens⁴

Besides the absolute numbers of personnel having increased substantially, the average remuneration rate per post has also risen sharply. Graph 5²⁰ below shows the unit cost per post (including non-clinical posts) from 2005/06 to 2015/16, in 2015/16 prices.

Remuneration increases averaged 4.5% above CPI for this period, resulting in the average cost per post in 2015/16 being 55% higher in real terms than it was in 2005/06.

Graph 5



Despite this substantial human resource improvement and the real rise in average remuneration levels, the public sector is struggling to improve quality standards.

Weak governance and poor leadership have resulted from widespread patronage (known as cadre deployment) and are major weaknesses that are undermining the gains made in medical personnel - we will elaborate more on this later in Sections 2.5 and 2.6.

The following quote²¹ by Eastern Cape MEC for Finance Mlungisi Mvoko in his budget speech in March 2021, is insightful of the practice of cadre deployment and its impact on public sector staffing:

*"In some departments you have a head of department, then four or five directors-general, then chief directors, then directors, then deputy directors, then assistant directors. It may not be the number of jobs [that is the problem], it is hierarchy."*²²

In contrast to the ratio of per capita medical personnel, the ratio of hospital beds per 10,000 uninsured citizens has declined over the past two decades.

As can be seen in Table 6²³, nationally the ratio has declined by 25%, with the Free State being the least affected province (-5%) and Kwa-Zulu Natal being the most affected (-34%) from 2003 to 2019.

²⁰ SA Health Review 2017: Blecher, et al

²¹ <https://www.dailymaverick.co.za/article/2021-03-10-medico-legal-claims-remain-eastern-capes-biggest-budgetary-headache/>

²² Author's Note: This seems extreme and has not been verified but remains an insightful statement by a senior Treasury official

²³ SA Health Review 2019 Health and Related Indicators, 2019 (Candy Day, et al)

Table 6

Year	2003	2005	2007	2009	2011	2013	2015	2017	2019	2019/03
RSA	24.0	22.7	22.1	20.9	20.0	19.3	19.1	19.0	17.9	-25%
EC	26.5	25.7	24.4	23.3	23.3	21.5	21.8	21.0	20.6	-22%
FS	20.9	21.0	21.4	20.9	20.6	20.3	20.1	19.9	19.8	-5%
GP	21.7	20.8	20.7	19.6	19.0	18.1	17.9	18.3	17.1	-21%
KZ	31.7	29.3	28.2	25.9	24.9	24.3	23.6	24.1	20.9	-34%
LP	20.1	18.1	17.4	16.3	15.3	15.3	14.0	14.6	14.2	-29%
MP	16.4	16.5	15.5	14.7	13.5	12.8	13.1	13.0	12.4	-24%
NC	22.3	21.8	21.0	20.4	18.6	18.0	18.4	20.2	17.7	-21%
NW	18.7	15.9	17.6	16.8	15.6	14.1	15.6	13.2	13.8	-26%
WC	23.8	23.3	22.4	22.0	20.6	20.5	20.8	20.3	20.0	-16%

< 16
16-18
> 18

Key: 2019 Hospital Bed Density per 10,000 uninsured citizens

The above data is the total of all 3 categories of public hospitals, namely district, provincial and central hospitals. In the source article published in SA Health Review 2019²⁴, the authors described a level of 18 beds per 10,000 uninsured citizens as being regionally saturated.

This obviously ignores the ratios of hospital bed types, so regionally a total may exceed 18, but there may still be shortages of specific hospital bed types (eg ICU beds). In 2003, only one province recorded a per capita level below 18 beds (Mpumalanga).

In 2019, five provinces recorded levels below 18 beds per 10,000 uninsured population (Gauteng, Limpopo, Mpumalanga, Northern Cape, and North West).

Across the 52 health districts in 2019, the bed density ranges from the lowest figure of 5.3 in District 37 in the North West to the highest figure of 41.7 in the Mangaung district in the Free State. Table 7 shows a distribution of the hospital bed densities across the 52 health districts in 2019:

Table 7

Bed Density per 10,000 Uninsured Population	Number of Districts	% of Total Districts	Cumulative % of Total Districts
> 20	16	30.8%	100%
18 – 20	1	1.9%	69%
16 – 18	7	13.5%	67%
14 – 16	8	15.4%	54%
12 – 14	12	23.1%	39%
10 – 12	5	9.6%	15%
< 10	3	5.8%	6%

It is clear that as the population has expanded over the past two decades and the strong urbanisation trend has further increased the population densities in the major urban areas, the DoH has not invested sufficiently in new public hospital beds, resulting in a deteriorating public sector hospital bed density.

²⁴ SA Health Review 2019, Health and Related Indicators, 2019 (Candy Day, et al)

The maintenance and condition of public hospitals has also been the subject of much press coverage over recent years, as numerous failings in care and safety issues come to the fore. The fire at Gauteng's Charlotte Maxeke Hospital in April 2021 is a recent example which has unearthed a litany of failings in occupational health and safety standards²⁵, with an estimated cost of nearly R400 million for reparations.

This occurred notwithstanding Gauteng's MEC Dr Bandile Masuku being quoted²⁶ in his 2019/20 budget speech as planning to spend R1 billion on *"maintaining and refurbishing its health facilities"* and *"ensuring that all clinics and hospitals comply to occupational health and safety standards"*.

2.4. Public Sector Subsidisation

This section looks to cover the extent to which the public health sector is funded, by way of subsidies or direct funding, by either the private healthcare sector, private companies, or private citizens. The most obvious direct form of funding is that of taxpayers, who fund virtually all government revenue and hence the public health sector's allocation from National Treasury (excluding donor funding).

The latest national health budget released in February 2021, indicated a total figure of R248.8bn for the 2021/22 fiscal year. On a per capita basis²⁷, this equates to a budget figure of R4,765 per uninsured person pa.

We can assume that all this funding is derived from either private individuals or private companies, paid across the various tax categories. The more implicit forms of funding of the public sector are broken down into the following categories:

- Medical scheme participation
- Out-of-pocket spending on private medical service providers
- Tax payable by private medical service providers
- State procurement of consumables from private suppliers

2.4.1. Medical Scheme Participation

According to the Council for Medical Schemes 2019 Annual Report, there were a total of 8 990 160 citizens covered by medical schemes as of 31 December 2019. Table 8 below compares the national health budget of 2019/20²⁸ (R222.6bn) on a per capita basis between total population versus uninsured population:

Table 8

Total Health Budget 2019/20 = R222.6 bn	Total Population 2019	Uninsured Population 2019	Difference = medical scheme lives	% Change
No of Citizens	58 560 000	49 570 000	8 990 160	-15%
Per Capita (pa)	R3 801	R4 491	R690	+18%

²⁵ <https://www.dailymaverick.co.za/article/2021-05-13-lies-and-cover-ups-what-the-charlotte-maxeke-fire-tells-us-about-health-and-safety-at-gauteng-hospitals/>

²⁶ <https://www.polity.org.za/article/masuku-prepares-gautengs-health-system-for-nhi-2019-07-31>

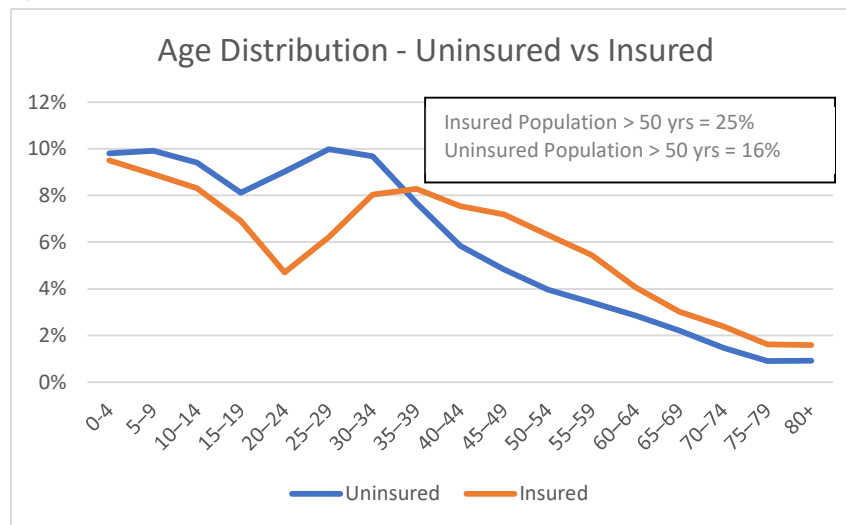
²⁷ StatsSA, Country Projection on Population by age, sex and race, 2020 - 2024 & CMS Annual Report 2019 (plus estimates)

²⁸ National Treasury, Budget Review 2019/20

The 8.99 million citizens who purchase their own private healthcare improve the per capita public health budget by 18% or R690 per uninsured person per annum. Using this as a basis, there is an improvement in the per capita health budget of R690 per uninsured person (i.e. for 49.57 million citizens), making this subsidy equal to R34.2bn for the 2019/20 fiscal year.

If we examine the difference in the age distributions of the uninsured and the insured population in Graph 6 below²⁹, it is evident that the insured population has a significantly older profile than the uninsured population.

Graph 6



Since age is the most significant driver of health costs, this is another implicit subsidy from the private sector to the public sector. It is beyond the scope of this document to quantify the value of this subsidy, but it is likely worth quantifying this value when establishing any future policy decisions on healthcare funding.

In 2019, 78.9% of all persons claiming a medical tax credit in their annual tax returns had gross income earnings of between R150,000 and R750,000 per annum³⁰. It is thus clear that the vast majority of medical scheme members are middle income citizens and not, as is often assumed, 'wealthy' citizens.

The same report indicated that 71.5% of the employees earning between R150,000 and R750,000 pa received a medical scheme subsidy from their employer.

The cost of medical scheme cover has risen sharply in real terms over the past two decades and affordability is highly dependent on a combination of the medical tax credit and employer subsidies.

Lower participation in medical schemes, as is envisaged in the NHI proposals, would serve to dilute the per capita public health budget, as illustrated above in Table 8. A lack of any technical assessment of this impact on per capita public sector expenditure under the NHI proposals is problematic.

²⁹ StatsSA 2019 Mid-Year Population Estimates 2019 / Council for Medical Schemes Annual Report 2019

³⁰ National Treasury, Tax Statistics 2019

2.4.2. Out-of-Pocket Expenditure

Out-of-pocket expenditure by both insured and uninsured citizens on private healthcare providers is another form of subsidisation of the public health budget by private citizens.

It is difficult to estimate the quantum of this spend, as it is not expressly or formally recorded anywhere. The two sources relied upon here are a report by the Council for Medical Schemes³¹ (CMS) and the General Household Survey³² (GHS), from Statistics SA.

The CMS report is limited to the out-of-pocket spend by medical scheme members only and it should be noted that the pattern or need for out-of-pocket spend will be different between insured and uninsured members.

The GHS 2019 reported that the percentage of households that, in the first instance of requiring treatment, consulted with a private doctor or facility was 27.5%.

This is considerably higher than the proportion of citizens who are members of a medical scheme (15.3%), implying that there is a significant portion of uninsured citizens who initially purchase private care on an out-of-pocket basis when required.

It is implausible that any significant spend by uninsured citizens is on in-patient care, as the cost of accessing in-patient private care on an out-of-pocket basis would be unaffordable. This spend is therefore presumed to be almost exclusively on out-patient primary and/or ambulatory specialised care services, such as doctors, specialists, dentists, etc.

The CMS report, based on 2013 data, estimated that the out-of-pocket spend by medical scheme members amounted to between R10bn and R15bn for the year, or between R2,588 and R3,881 per insured family (household).

Total claims paid by medical schemes in 2013 was just over R101bn, meaning that the above out-of-pocket estimate amounted to between 9.9% and 14.8% of the actual full cost of private treatment.

The CMS report did note that the out-of-pocket data may be underestimated due to non-collection of these amounts by medical schemes and/or non-submission of these claims by members to their medical schemes once insured benefits have been depleted within any given benefit year.

2.4.3. Taxes on Private Medical Providers

We can estimate what private sector revenue is from assessing medical scheme expenditure and the above assessment of out-of-pocket expenditure. The latest medical scheme annual report³³ shows that collectively medical schemes paid benefits of R185.8bn in 2019 (risk benefits and medical savings accounts).

The out-of-pocket expenditure assessment above showed that medical scheme members contributed somewhere between R10bn and R15bn in 2013. If we extrapolate that forward using CPI as a conservative increase factor, this expenditure would be between R13.5bn and R20.3bn in 2019. This also ignores the out-of-pocket spend made by uninsured citizens.

³¹ Research Brief 2013: Out of Pocket Costs

³² GHS, 2019

³³ Council for Medical Schemes Annual Report 2019

If we assume conservatively an additional spend on the private sector by uninsured citizens of a further R15bn³⁴ for 2019, then we get to a total expenditure in the private sector of between R234.3bn and R241.1bn.

From a VAT perspective, that could equate to taxes of roughly R31 billion pa³⁵.

The 2019 GDP³⁶ for SA was R5.1 trillion, so collectively these activities constitute between 4.6% and 4.7% of the total economy.

This is a significant contribution to the national economy. According to a study performed by Econex³⁷, the activities of the three major private hospital groups³⁸ generated tax revenue of 18.9bn (direct and indirect) in 2016 and supported 248,504 jobs or 1.57% of national employment (also direct and indirect).

In the context of this document's focus on the NHI proposal, it is concerning that throughout the NHI policy process, there has been no assessment made at all of what the impact the NHI proposal will have on government's tax revenues from existing private sector activities.

Note: The issue of what will happen to government's VAT revenue from private medical service providers is somewhat complicated by a few unknown factors. The first is that, while private sector services are subject to VAT, public sector services are not. The NHI proposal is to contract both public and private sector service providers to deliver NHI funded care (known as plurality of provision).

However, private sector providers will be at an obvious price disadvantage because of this VAT differential. Other factors creating a price disadvantage between the sectors are corporate tax, malpractice insurance, short term insurance, rates and cost of capital.

So, it remains uncertain as to how the NHI proposal is going to create parity between public and private service providers in obtaining a plurality of provision.

This is another example of a recognisable technical issue not being dealt with during the policy process.

2.4.4. State Procurement on Consumables

The last sub-section here will discuss the implicit subsidy the state receives from the private funding sector through the state's procurement of consumables (including medicines).

Private sector suppliers typically tender at discounted prices to the state and subsequently recoup this loss of margin through higher procurement prices to the private sector.

As data is not published to enable quantification and contract data on procurement by the state from private suppliers is confidential, it is impossible to assess a quantum on this subsidy. Nonetheless, it is common knowledge that the state can procure at substantial discounts, given its very large volumes.

While we cannot quantify the subsidy, we can focus on the principle at play and how it will evolve in view of the NHI.

If we accept the premise that the state receives lower prices and the suppliers make up the discount values from the private sector, this subsidy will then either fall away, or at least diminish under NHI, since the NHI proposals are for it to be the monopoly purchaser in the country.

³⁴ Assuming an approximate spend of R300 per uninsured person pa

³⁵ This is likely overstated as there are some individual practices where turnover is under R1m and hence may not be VAT registered

³⁶ StatsSA, Gross domestic product, Fourth quarter 2019

³⁷ Econex: Private hospitals' contribution to the South African economy (2016/17), September 2017

³⁸ Life, Mediclinic and Netcare (they constitute approximately 75% of total private hospital beds in SA)

There will be no purchasing by the private sector where the suppliers can recoup profit margins. The average price paid nationally for a monopoly purchaser would have to fall somewhere in-between the prices that the state and the private sector pay now.

If the NHI Fund were to dictate price on tenders below what would produce an overall fair margin for suppliers, they would either go out of business or exit the country (assuming some current suppliers are not local).

It is a disconcerting fact that, despite this subsidy being a recognisable technical issue, it has not been addressed or evaluated during the NHI policy process (see Section 4).

2.5. Medical Malpractice Liability

It is now a well-established fact that South Africa's public sector is pervaded by high levels of numerous corrupt activities.

The Zondo Commission of Inquiry into State Capture has highlighted the extent of this pervasiveness and will likely lead to lengthy and elaborate prosecutions that will take many years for the National Prosecuting Authority to bring to the courts.

A study undertaken by GAPP³⁹, and submitted to the Zondo Commission, laid out in detail the historical political contestations for senior public sector careers by members of the country's ruling party, the African National Congress (ANC).

These public sector careers led to unencumbered access to vast public resources.

Once in the positions of power, these leaders repurposed public sector projects (and their budgets) to fund the ANC's growing requirement for huge electoral budgets to ensure electoral victories. This fomented an ongoing cycle, as winning at the polls ensured access to public sector budgets and such access to budgets led to electoral victory.

In this process lay the birth of what has become widely known in South Africa today as *State Capture*.

It was inevitable that, with unfettered access to such vast sums of public monies, greed led to corruption that has expanded so pervasively, that it now encompasses virtually every State-Owned Enterprise (SOE) and public department in government.

In the submission by GAPP to the Zondo Commission, they concluded as follows:

"The ANC was unable to maintain its cohesion as various networks clashed internally.

Some of these networks, especially those who later came to cluster around Jacob Zuma, turned to corrupt and criminal activities to sustain their political lives and to seek power and/or maintain power in the ANC.

The politicisation of government administrations, as well as the transposition of internal party antagonisms into departments and State-Owned Enterprise[s], rapidly collapsed

³⁹ Making Sense of State Capture in South Africa, Ivor Chipkin - Government and Public Policy Think-tank (GAPP)

their organisational capacities, as budgets were repurposed, and as political appointments crowded out those with technical expertise.

With the erosion of state capacity (and with the failure to build it up) the South African government has proved unable to implement any of its major policies, from creating a stable supply of electricity, to delivering decent public education, to improving safety and security for South African citizens or to providing quality public healthcare.”

Evidence of corruption in the public health department has been highlighted through extensive investigative media coverage⁴⁰. The highly publicised scandal⁴¹ on procurement of Personal Protection Equipment (PPE) during the 2020 Covid-19 pandemic was an overt example. So was reporting⁴² by the investigative journalist team, Scorpio, on procurement of communication services ordered by the Minister of Health in 2019 to promote the government’s proposed National Health Insurance (NHI).

In July 2020, Corruption Watch released a report⁴³ specifically focused on corruption in the public health sector. The report outlines in detail the extent of corruption, through what mechanisms it occurs, how it is done and at what level within the public sector it occurs – the report concluded:

“The hundreds of corruption cases received by Corruption Watch and discussed in this report illustrate the significant problem plaguing the health sector in South Africa.”

The latest Auditor General’s report⁴⁴ is also indicative of the extensive levels of corruption, wastage, and unauthorised expenditure in the DoH. The following quotes from the then Auditor General and the Health Ombud in 2019 are indicative of the problems besetting the DoH:

Professor Malegapuru Makgoba, The Health Ombudsman
“I think the state of healthcare it’s collapsing!”

Kimi Makwetu, The Late Auditor General
“The country’s health services are in crisis!”

An obvious result of these pervasively corrupt activities is a degradation in the quality of care. The resultant susceptibility that the state is exposed to in legal cases against it for medical malpractice, is reflected in the state’s massive and rapidly growing medical malpractice liability.

Malpractice liabilities also occur perniciously, where clinical records are destroyed or stolen to prevent the state defendants from being able to defend cases. Nonetheless, such action is grounded in corrupt behaviour.

The growth in the medical malpractice liability compelled the Minister of Justice to request the SA Law Reform Commission to undertake research⁴⁵ on the matter and offer recommendations.

Their paper mainly dealt with legal aspects of the rise in medical malpractice liability claims and possible legal solutions to dealing with them. It also highlighted that there are certain complexities that can be contributing factors to these claims.

⁴⁰ <https://www.dailymaverick.co.za/article/2021-01-26-gauteng-department-of-education-spent-r431-million-in-three-months-on-unnecessary-deep-cleaning-and-decontamination-of-schools/>

⁴¹ <https://www.dailymaverick.co.za/article/2021-02-08-the-state-has-learnt-hard-lessons-about-covid-19-theft-but-the-net-is-closing-on-fraudsters/>

⁴² <https://www.dailymaverick.co.za/article/2021-03-06-department-of-health-suspends-dodgy-r82m-covid-19-communications-contract/>

⁴³ https://www.corruptionwatch.org.za/wp-content/uploads/2020/07/Corruption-Watch_R4_FINAL.pdf

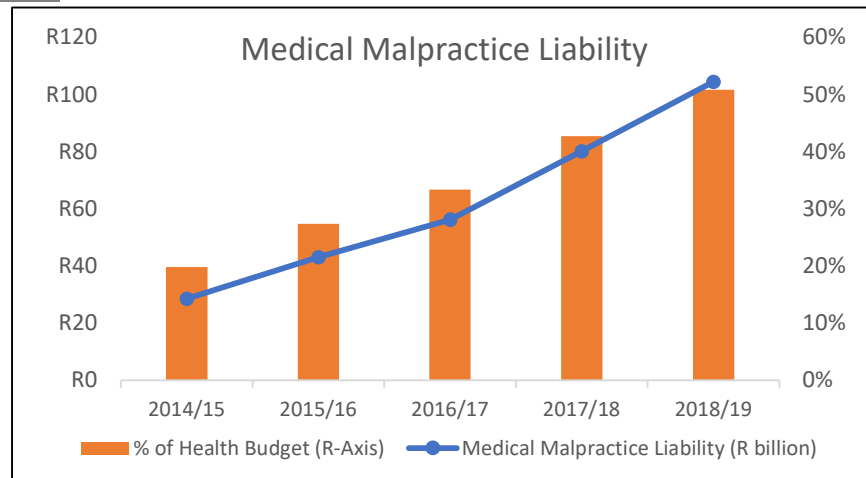
⁴⁴ Consolidated General Report on National and Provincial Outcomes, PFMA 2019-20

⁴⁵ SA Law Reform Commission, Issue Paper 33, Project 141, Medico-Legal Claims, 20 May 2017

Some of these items were lawyers, who specialise in liability claims, diverting focus away from claims against the Road Accident Fund towards the DoH, greater awareness of rights by patients, better access to information and higher levels of medical specialisation.

Notwithstanding the reasons, the growing financial liability is a cause for major concern and further efforts need to be made in terms of improving the standards of healthcare to limit exposure to liability. Graph 7 below shows how these claims against the state have grown exponentially in recent years, averaging an increase of R19.0bn per annum from 2014/15 to 2018/19⁴⁶.

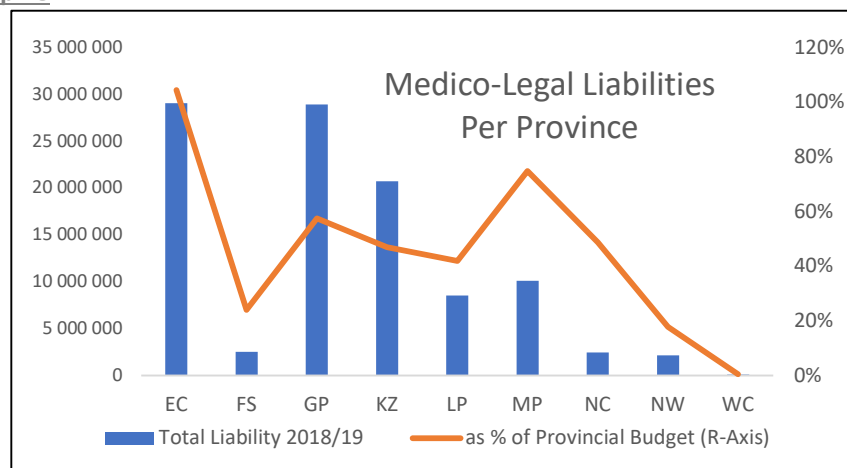
Graph 7



The same study quoted above corroborates the Auditor General's Annual Report (2019/20), recording the national liability for medical malpractice liabilities at R105.8bn, which represents 42.5% of the total current annual health budget for the country (R248.8bn – 2021/22).

Graph 8 below is also derived from the same study and shows the medical malpractice liability at a provincial value (nominal) and as a percentage of each provincial budget.

Graph 8



⁴⁶ SA Health Review 2019 (Achieving high-quality and accountable universal health coverage in South Africa, Laetitia Rispel, et al)

The total medical malpractice liability equates to 50% of the combined provincial budgets.

The Eastern Cape (104%) and Mpumalanga (75%) have the highest liabilities as a share of their respective provincial budgets and as these liabilities become payable, budget allocations are being redirected away from health expenditure, thereby further threatening these provinces' ability to deliver health services.

The figures shown in Table 7 below are for the 2018/19 financial year. However, according to a press release⁴⁷ quoting Eastern Cape MEC for Finance, Mlungisi Mvoko, the province's medical malpractice liability has ballooned further from R29bn in 2018/19 to nearly R37bn as at the reported date of March 2021. This is well in excess of the Eastern Cape's total current annual health budget, and it represents 14.9% of the country's entire national health budget for 2021/22 of R248.8bn.

This provision has similar attributes to government borrowings in that they are not payable immediately, but once they amass to these levels, they can threaten the country's long-term financial stability. If the above national trend continues, this liability will equal R218bn by 2024/25, which will equate to 78% of the DoH's entire annual budget⁴⁸.

Unless the DoH can address the poor quality of care in the public sector and the levels of corruption that persist, these growing liabilities will massively hamper the state's ability to improve healthcare. Sadly, this has become a vicious cycle, as one failing (exposure to liability) leads further to the other failing (poor quality healthcare) which leads to further liability and so on and so forth.

In our opinion, this matter is not receiving the urgent attention it deserves. Instead of a focus on the quality of care delivered, it appears that the only corrective attempts being made are at avoiding or delaying liability payments through litigation or attempts to legally alter the form of compensation.

In the matter brought before the High Court in 2020 by the Gauteng MEC for health, and eventually appearing before the country's apex court in April 2021, Justice Mbuyiseli Madlanga ruled that compensation in these matters may not only be considered by the courts in the form of an immediate payment of a lump sum equating to the defined loss⁴⁹.

It was agreed by the Constitutional Court Justice⁵⁰ that courts could consider alternative compensation in the *'form of services, or the provision of medical and related items, or to pay the amount of money in future as and when the need arose'*.

However, Justice Madlanga emphasised that these alternative forms of compensation did not mean that the interests of the injured parties *"must be relegated to insignificance"* and that *"Each [injured party] must be afforded an appropriate remedy and compensated fairly for loss suffered."*

Given that one of the potential alternatives of compensation from the state will be an offer of treatment from the very same failed public health services that resulted in the initial compensation being awarded, it will be very difficult for state defendants to argue that this is an appropriate form of compensation.

It is also plausible that applicants' lawyers are likely to shift greater focus in their arguments toward emotional pain and suffering, as compensation is likely to be awarded only in monetary terms. Since

⁴⁷ <https://www.dailymaverick.co.za/article/2021-03-10-medico-legal-claims-remain-eastern-capes-biggest-budgetary-headache/>

⁴⁸ Assuming the same annual rate of increase in the liability and an average budget growth of 4% pa from the 2021/22 budget of R248.8bn

⁴⁹ Known under the common law as the "once and for all" rule

⁵⁰ <https://www.dailymaverick.co.za/article/2021-04-07-soaring-medico-legal-claims-against-state-hospitals-courts-may-consider-forms-of-compensation-other-than-lump-sum-payments/>

the clients of the attorneys who take these cases are mostly lower income citizens, the attorneys usually take these cases on a full-risk basis, where they are only compensated for their services if there is a monetary award by the courts.

This will likely ensure that these cases are as heavily focused on monetary awards as possible rather than alternative forms of compensation.

In closing here in this section, it is also concerning that there has been no discussion or analysis of where this liability is going to rest in an NHI world. Will the state transfer the existing liability to the NHI Fund or retain it within its own balance sheet? If it transfers this liability to the NHI Fund, it will technically be insolvent before it has even started. How is this going to be dealt with?

How will future malpractice liabilities that arise be treated? Will these liabilities rest with the individual facilities or providers? If so, will there be an inclusion within the reimbursement structure to accommodate such costs, or at least the cost of insurance for such liabilities?

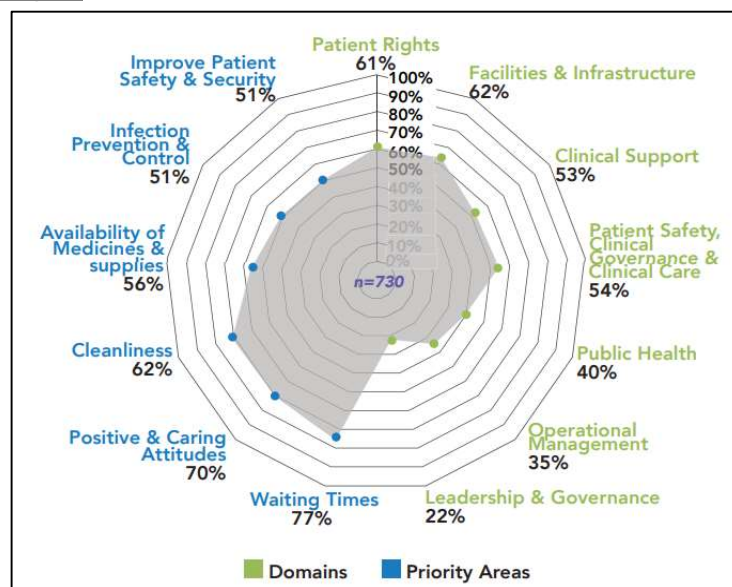
Is there a willing insurance market ready to take on such liabilities that will exonerate providers from these liabilities? Many insurers have withdrawn from this market in recent years, so medical providers may not even be able to find insurance to cover their liabilities.

Again, this is an example of critical technical issues that have not been assessed in the policy process.

2.6. Office of Health Standards Compliance

Graph 9 below shows the national outcomes from the 2018/19 inspection report⁵¹ of the Office of Health Standards Compliance (OHSC), categorised in the 13 measurable criteria listed in the graph.

Graph 9



⁵¹ OHSC Annual Inspection Report, 2018/19 (Dec 2020)

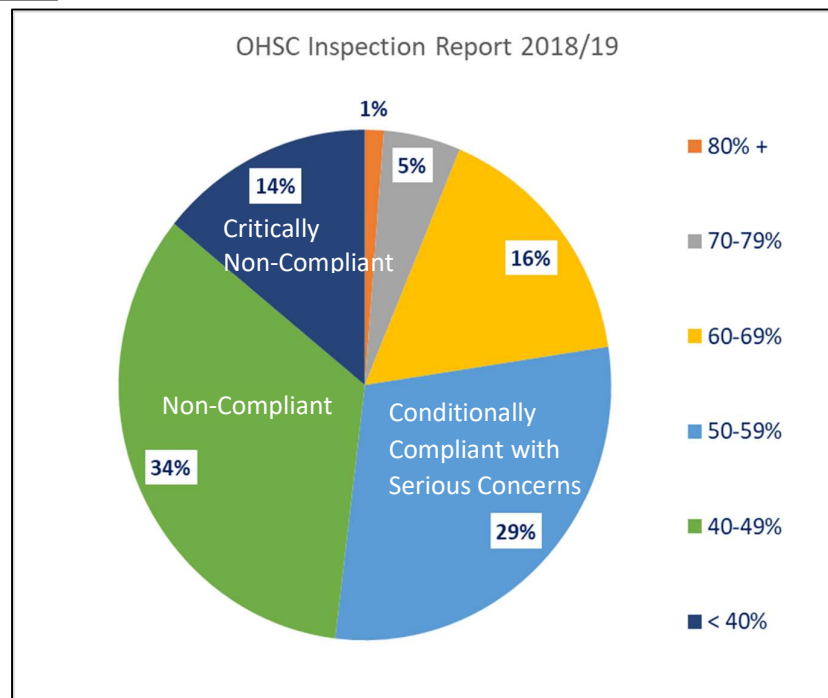
The quality domains are mostly structural. The six priority areas for measurement are waiting times, cleanliness, values and attitudes, availability of medicines, patient safety, and infection prevention.

Of major concern is the poorest score across all 13 of these metrics, namely 'Leadership and Governance' with a national average score of 22%. Across most clinics and community health centres this score was exceptionally low, most notably in the Eastern Cape and Limpopo, where this score was dismal (typically less than 10% compliance).

The OHSC's 2018/19 score card shown in Graph 10 below paints a bleak picture – only 22% of the 730 inspected facilities were graded in a category considered compliant with a score of 60% or more (i.e., compliant, compliant with recommendations or conditionally compliant).

The balance of 78% of facilities inspected were graded as conditionally compliant with serious concerns (29%), non-compliant (34%) or critically non-compliant (14%). The following health establishment types and numbers were graded in the inspection report - community health centres (n=49), clinics (n=631) and hospitals (n=50).

Graph 10



The NHI Bill proposes to use an OHSC inspection score of 80% or more as the qualifying criteria for accreditation with the NHI Fund.

Considering that only 1% of public facilities achieved an 80%+ score in this and the previous two inspection reports by the OHSC, it is abundantly clear that the public health system will not be able to operate in such a binary system, which leaves 99% of the facilities that are below the 80% accreditation score with zero revenue under NHI proposals.

Such a binary system (i.e., accredited vs not accredited) is not incremental, as it requires immediate compliance in order to receive funding from the NHI Fund.

It is patently obvious that for the vast majority of institutional public providers, implementation of the NHI creates an existential concern for them. Government will be placing undue pressure on these institutions with this proposal, with no transitional plan of how they will operate in circumstances where they do not meet the accreditation requirements.

Notwithstanding that most institutional public facilities are not juristic entities, and thus legally incapable of entering into legal contracts with the NHI Fund, this is a massive failing of the NHI proposal which further exemplifies the inadequacy in technical analysis work undertaken during the policy process.

There is nothing coherent or reasonable in excluding 99% of the public sector facilities from providing care to the population. In the context of what is proposed this can only be described as reckless!

The following is a quote from a report we also referenced earlier⁵²:

“Notwithstanding the enabling Constitution, strong health legislation and numerous health policies that express Government’s commitment to a high-quality health system, gaps in ethical leadership, management and governance contribute to poor quality of care. These gaps are exacerbated by mismanagement, inefficiencies, and incompetence at various levels of the health system. Corruption and fraud are major threats to equitable access to quality health care.”

The very poor scores on ‘Leadership and Governance’ in the OHSC report corroborates the above view, as well as our own opinion, that it is not a lack of resourcing that is the prevalent problem in the public sector, but rather cadre deployment of unqualified personnel that results in poor leadership, inadequate governance, and pervasive corruption.

Additional commentary from the same lead-author above, the lack of leadership and governance being at the source of public sector problems is elaborated on further below⁵³:

The entrenched inequality and poor health outcomes in South Africa are underpinned by three main ‘fault lines’.

The first of these is a failure of leadership, management and governance across the health system that results in a ‘tolerance of ineptitude’ and general failure of accountability.

The second is that the district health system is not fully functional and the third is the failure to address the crisis in South Africa’s health workforce.

These challenges in South Africa’s health system are deeply entrenched and can only be confronted through fundamental reforms and redistribution.

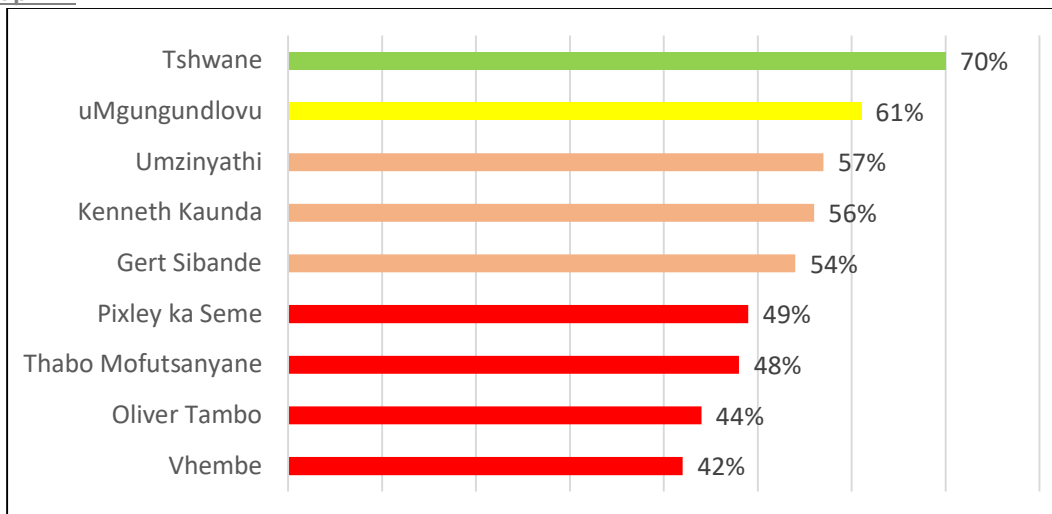
In closing this section, Graph 11 below shows the OHSC’s 2016/17 inspection score for nine of the ten NHI pilot sites that were established as test runs for NHI – the average score is 53%.

The dramatic failure of these pilot sites has largely been ignored in the NHI policy process.

⁵² SA Health Review, 2019: Achieving high-quality and accountable universal health coverage in South Africa (Rispel, et al)

⁵³ SA Health Review 2016, Rispel L. 2016. ‘Analysing the progress and fault lines of health sector transformation in South Africa’

Graph 11



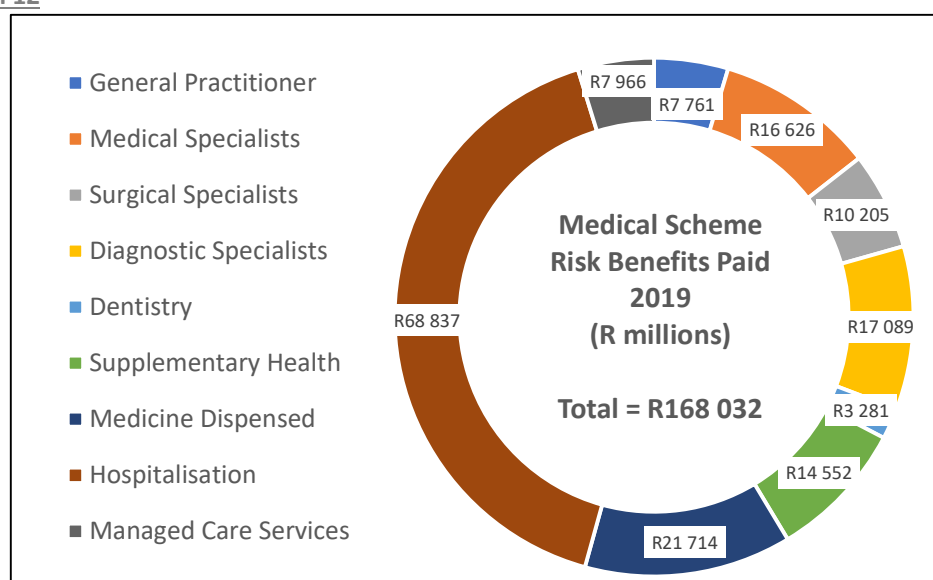
3. Private Health System

3.1. Overview

South Africa's private healthcare industry is a substantial and well established sector that generally delivers high quality care across the spectrum of clinical categories. It has, however, suffered from substantial cost increases over the past two decades and has numerous areas of inefficiency (see Section 3.2). Monthly contributions to medical schemes are typically ranked in the top 5 largest household expenses.

The total medical scheme risk benefits paid in 2019 per medical discipline are shown in Graph 12⁵⁴.

Graph 12



Considering that there were 8.99 million medical scheme beneficiaries in 2019, per capita medical expenditure by schemes equated to an average of R18,805 per annum. Factoring in total contributions, which include administration costs, reserve allocations and deposits into medical savings accounts, total per capita contributions by members in 2019 equated to R23,305 per annum.

The total medical tax credit allowance in 2019 was R26.2 billion, or R2,914 per medical scheme beneficiary per annum⁵⁵. This effectively means that 87.5% of contributions to medical schemes were made with private after-tax money.

According to a study by Econex⁵⁶, in 2016/17 there were an estimated 40,702 private hospital beds in SA. According to the Council for Medical Schemes⁵⁷, at the end of 2016 there were 8,878,081 beneficiaries covered under medical schemes, providing a hospital density ratio of 45.8 beds per 10,000 lives for the private sector.

⁵⁴ Council for Medical Schemes Annual Report 2019

⁵⁵ National Treasury, Tax Statistics 2019

⁵⁶ Private hospitals' contribution to the South African economy (2016/17)

⁵⁷ Council for Medical Schemes Annual Report, 2016

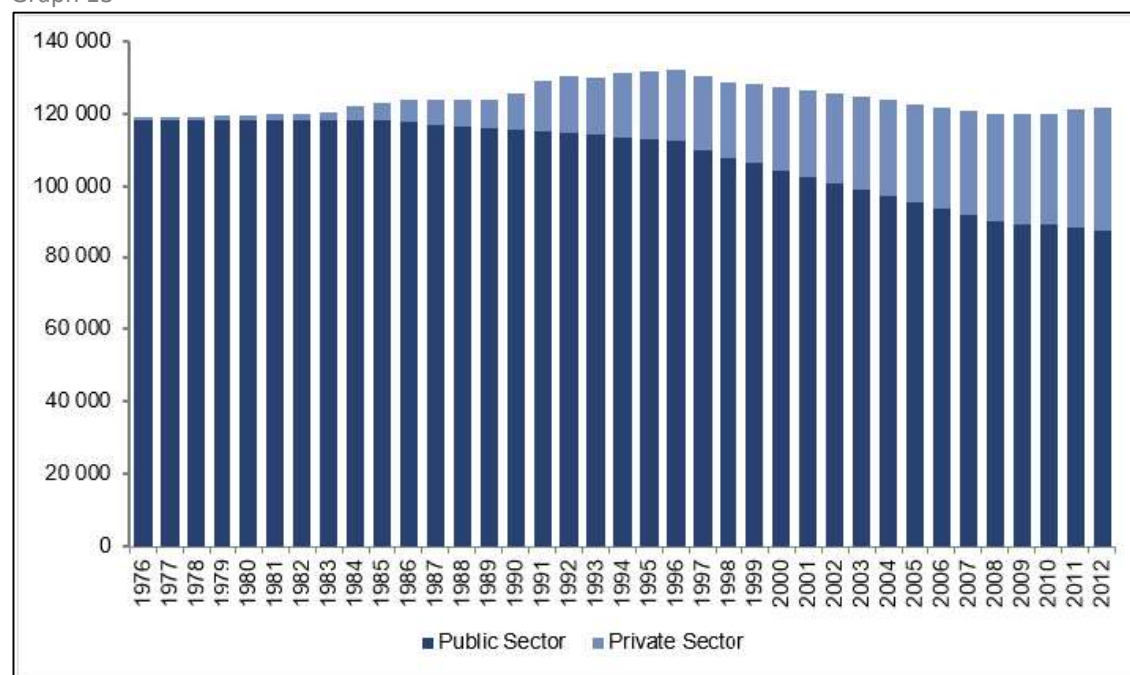
This ratio is considerably higher than the public hospital bed density ratio of 19.0 per 10,000 uninsured citizens in 2017 (see Section 2.3).

The growth in private sector hospital beds has been substantial since the early 1990s when there were only about 10,000 private beds. The quality the public sector delivered prior to the early 1990s was high which meant that there was insufficient demand for private beds to support private sector expansion.

However, as the number of public sector beds declined, and their quality of care also deteriorated, private sector hospitals expanded rapidly to meet the demand from privately insured patients. Total hospital beds in the country peaked in 1996 and although private beds grew since then, they have not fully supplemented the losses of public sector beds.

Globally, as technology and skills have improved and more efficient use of hospital-based services have been applied, admission rates and lengths-of-stay have been in decline since about 1980⁵⁸. This has translated into fewer beds being required.

Graph 13 ⁵⁹



3.2. Health Market Inquiry

The Health Market Inquiry (HMI) was launched in 2013 by the Competition Commission to investigate the state, nature and form of competition in the private sector, on the understanding that there are features of the sector that prevent, distort or restrict 'robust' competition.

The HMI spanned six years and took the form of evidence gathering from all stakeholders and detailed data analysis to produce its findings and, importantly, its corrective recommendations.

⁵⁸ Health Affairs, Anderson G et al (2001)

⁵⁹ Econex, Occasional Note June 2016

The HMI confirmed that the private sector had been experiencing substantial cost increases over the past two decades, but more importantly it provided a number of recommendations to strengthen competition in the market and to ensure that such competition was based on value (i.e. a combination of price, quality and health outcome).

In particular, the HMI found that there had been insufficient regulatory oversight from government and health regulators⁶⁰:

“We have found there has been inadequate stewardship of the private sector with failures that include the Department of Health not using existing legislated powers to manage the private healthcare market, failing to ensure regular reviews as required by law, and failing to hold regulators sufficiently accountable. As a consequence, the private sector is neither efficient nor competitive.”

Two regulatory recommendations from the HMI are the establishment of a supply-side regulator and an organisation to monitor and report on clinical outcomes. These are examples of some of the regulatory interventions that the DoH should have implemented to assist in cost containment in the private sector.

The funding side of the market is currently regulated through the Council for Medical Schemes, but the supply side is currently not well or evenly regulated. The HMI concluded that because the supply side of the market is largely unregulated there are *“negative consequences for competition and for the consumer”*.

The organisation to report on outcomes will serve to *“... provide practitioners and hospitals with relevant outcome information and ways to improve clinical quality, and, secondly, to provide patients and funders with relevant choice information on health outcomes”*.

The HMI found further that the regulatory framework that medical schemes have been operating in since 2000, when the current Medical Schemes Act (MSA) 131 became effective, created incentives for medical schemes to compete based on benefit design rather than value metrics and is inadequate in countering anti-selective behaviour by consumers:

“The social solidarity principles of open enrolment (schemes must accept all applicants) and community rating (schemes must charge a contribution price for a particular plan which is identical for all members no matter age, sex or pre-existing conditions) were always meant to be implemented alongside a risk-adjustment mechanism (schemes with above average risk-profiles are balanced through funds received from schemes with below average risk-profiles) and mandatory membership.”

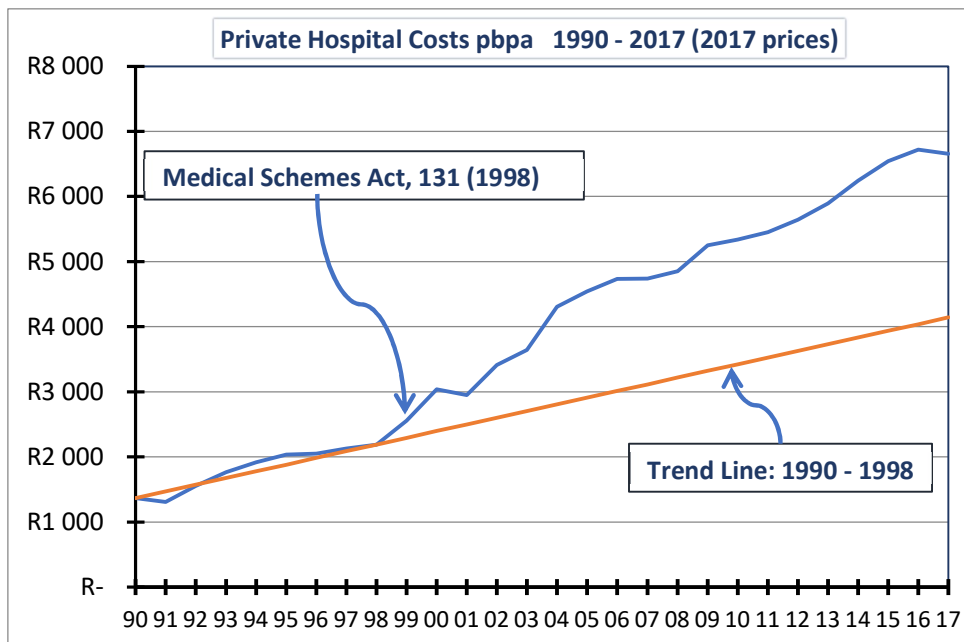
The original medical scheme proposals in the late 1990's included mandatory membership, but this provision was removed from the legislation at the 11th hour after protest from labour unions. This left an unbalanced regulatory framework in place that has exposed consumers to ever-growing- above-inflation-cost increases because the strong social solidarity rights retained in the MSA allowed opportunistic anti-selective behaviour against schemes.

In Graph 14⁶¹ below, we can see that private hospital costs more than doubled in real per capita terms over a period of 14 years between 2000 and 2014, far exceeding the trend line of hospital cost increases in the 1990's.

⁶⁰ HMI Executive Summary, Sep 2019

⁶¹ Council for Medical Schemes Annual Reports and Research Brief No 1 (2008)

Graph 14



A consolidation of ownership of private hospital beds also occurred around 2000, with the three major hospital groups⁶² shifting their collective ownership from about 50% to nearly 80% of private beds by about 2002. This formed an oligopoly which has been blamed for the substantial increase in hospital costs. However, the anti-selective behaviour permissible under the provisions of the MSA will also have contributed substantially to this rise in costs.

A risk-adjustment mechanism (RAM), then known as the Risk Equalisation Fund (REF), was investigated for a number of years by the CMS along with medical schemes and other stakeholders, but these proposals were eventually abandoned in 2008 when the NHI proposal was first mooted.

Another recommendation from the HMI, which is not new or novel, is the establishment of a single, comprehensive, standardised base benefit option, to be offered by all schemes. This will enable consumers to easily compare the equivalent offerings from medical schemes based on their price and service. This, along with an appropriate RAM, would lead to schemes competing on value rather than on benefit design and subsequently cherry picking younger healthier members.

The final recommendations of the HMI are more comprehensive than what has been reviewed in this section and are robust evidence-based findings that took six years to develop and have been in the public domain since September 2019.

The private sector remains under substantial cost pressure, as it has been for two decades, and to become more expansive and meet the needs of more citizens, these recommendations should be welcomed, in order that the private sector can serve a greater segment of the population.

However, given the overt focus on the NHI proposals, there has been no indication from any government body that the HMI findings are to be implemented.

⁶² Life, Mediclinic and Netcare

3.3. Changes in Tax Subsidies

The overarching principle of providing tax relief to consumers on purchasing their own private healthcare insurance is an obvious incentive to relieve the government from catering for the healthcare needs of those citizens. As noted in Section 2.4.1, the extent by which citizens participating in private medical scheme cover subsidises public sector expenditure is very substantial (R34.2bn for 2019/20).

There have been two major changes to the tax regime over the past 25 years, affecting the cost of private insurance and the tax relief received in funding private health insurance costs.

The first was the inclusion of value added tax (VAT) on all private medical services in the 1990's⁶³. This had a dramatic and sudden impact on private healthcare costs that were previously exempted from VAT. This additional cost was obviously immediately passed on to participating citizens via increases in their prepaid contributions to their medical schemes.

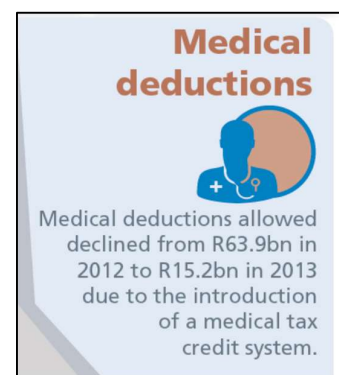
Medical schemes cannot register for VAT and thus cannot obtain relief on expenses that are subject to VAT. Subsequently, subsidies by employers for medical scheme contributions cannot be claimed as a VAT expense and private citizens are also not eligible to claim VAT expenses, so the full cost of this change was borne immediately by the citizens utilising the private sector.

The second major change was the conversion in 2013/14 from a tax deduction on medical scheme contributions to a fixed medical tax credit for medical scheme participation. The principle of the conversion was to create a more progressive tax system, whereby the tax relief became an equal tax credit for each participating citizen, rather than the full contribution to the medical scheme being fully tax deductible. The previous system was less progressive, as the monetary value of the tax relief was the highest for the highest income citizens who participated in the most expensive medical scheme benefit options.

However, in the process of the conversion, the overall value of tax relief provided dropped substantially from R63.9bn in 2012 to R15.2bn in 2013⁶⁴. The total tax deduction of R63.9bn in 2012 represented 54.1% of the total contributions to medical schemes in that year, whereas the deduction of R15.2bn represented a substantially reduced 11.7% of the total medical scheme contributions in 2013⁶⁵.

Both these changes to the tax treatment of private healthcare services represented a substantial increase in the cost of maintaining pre-funded private healthcare in SA.

Whilst the change from a tax deduction to a tax credit was, in principle, progressive, the fact that the overall value of the relief was so dramatically reduced in the conversion process was regrettable, as it hampered expansion of the private sector.



Alongside the governance and regulatory failings outlined by the HMI in Section 3.2 above, it is clear that, if SA had a well-functioning private sector with adequate tax incentives to participate, it would have provided a substantial improvement to the public sector's funding levels, since a much greater proportion of private citizens would have medical scheme membership.

⁶³ The VAT rate at the time was 13%

⁶⁴ SARS Annual Report, 2013

⁶⁵ CMS Annual Report, 2013

4. National Health Insurance

4.1. Overview

In 2009, the then Minister of Health⁶⁶ established the Ministerial Advisory Committee (MAC) to guide and establish policy on development of a NHI proposal. This led to the publication of the NHI green paper in 2011 and two further white papers in 2015 and 2017. In 2018, the draft NHI Bill was published, and the final Bill passed by Cabinet in July 2019.

The NHI is a very high-risk proposal that will cause drastic, sudden and substantial changes to both the public and private health sectors simultaneously. The policy process has been characterised by an obtuse focus on the centralisation of the funding of both these sectors - into a national single-payer, called the NHI Fund (NHIF) - touted heavily as being a silver bullet that will resolve the country's healthcare problems.

'Silver bullet' on its way to being reality Mkhize tells parliamentarians

JULY 10TH, 2019 SOUTH AFRICA

The extent to which inaccurate problem statements have been made by senior public officials is concerning. The following is a quote from Health Minister, Dr Zweli Mkhize, from a parliamentary Q&A session⁶⁷ in 2019:

"The primary reason for this shortage [of doctors] is that the public health sector budget has not increased in real terms for the past 10 years. This has impacted the number of staff that can be appointed".

However, as our analysis from Section 2.1.1 shows, in real terms measured on a per capita basis, the public sector health budget more than doubled from 2000 to 2020. Even if we assess the budget over a similar time period as quoted by the Minister above, measured on a real per capita⁶⁸ basis, the budget from 2010 to 2020 increased by 28.2%.

These are substantial inaccuracies that have underpinned government's proposals from the outset of the NHI policy and maintained throughout the entire policy process.

These inaccurate comments are echoed in the quotes below by Dr Olive Shisana, chairperson of the MAC on NHI for almost 10 years and currently advisor on NHI in the Presidency. These comments strongly indicate that this proposal is more politically motivated than by any specific identified need:

"This [the NHI] is an instrument to end the race, class, gender [sic] divisions that continue to plague South Africa. For example, 76% of medical scheme members are white, and only 10% are black Africans. If medical schemes are allowed to offer the same services as NHI, most of the specialists, doctors, dentists, and allied health professionals will simply provide care to the mostly white people and leave black African people with under-resourced providers. This maldistribution of human resources is at the root of the health care crisis."

The intended political influence of these declarations is self-evidently populist, but similar to the Minister's statement above, they are grossly inaccurate. Nearly 50% of medical scheme members are black/African and slightly more than a third are white⁶⁹.

⁶⁶ Dr Aaron Motsoaledi

⁶⁷ <https://businesstech.co.za/news/business/350061/south-african-healthcare-workers-say-they-are-emigrating-because-of-the-nhi/>

⁶⁸ 'Real per capita' accounts for increases in general inflation and the uninsured population

⁶⁹ General Household Survey 2019, StatsSA

The supposed maldistribution of healthcare professionals stated by Dr Shisana is also a red-herring.

Table 9 below⁷⁰ is from the most recent report by the DoH on human resources. Given the 2011 date of this report, these numbers also partly ignore the very substantial increase in public sector employment numbers from 2006 to 2016, as outlined in Section 2.3 above.

Table 9

The distribution of health resources between the public and private systems as reflected by the National Department of Health human resource strategy in 2011					
	Public	Private	Total	Public	Private
Medical practitioners	11 875	7 359	19 234	61.7%	38.3%
Medical specialists	4 444	6 658	11 102	40.0%	60.0%
Nurses	120 157	42 489	162 646	73.9%	26.1%
Allied	34 010	28 745	62 755	54.2%	45.8%
Clinical support	67 861	7 581	75 442	90.0%	10.0%
Total	238 347	92 832	331 178	72.0%	28.0%

In Section 2.3 we showed that in 2016 there were 14,545 and 4,990 medical practitioners and medical specialists respectively working in the public sector. These figures are 22.5% and 12.3% higher respectively than the 2011 figures shown in Table 9 above, meaning that the overall public-private ratio of 72%:28% (also shown in Table 9) would have increased in favour of the public sector since 2011.

Thus, the argument that a maldistribution of human resources between the private and public sectors is at the heart of the problem in our healthcare system is also entirely inaccurate.

There is no doubt that overall, the country has a shortage of doctors but the primary cause of this is that we simply do not produce enough medical graduates (see our analysis in Section 4.4).

The following are the key points of policy process failure that have characterised the development of the NHI proposals:

- A lack of clarity on the rationale for the policy proposal. In our evaluation of the Socio-Economic Impact Assessment (SEIA) in the next section, we outline how there is a major disconnect between reality and the problem statement.
- A virtual absence of technical and feasibility analyses, despite the Ministerial Advisory Committee having been in place for ten years since 2009. This is an extremely concerning aspect of this proposal, as the magnitude and nature of the proposals will drastically and immediately disrupt both the public and private sectors simultaneously.
- A complete absence of a detailed technical costing analysis. The cost estimate of R256bn⁷¹, originating in the 2011 Green Paper and carried forward throughout both White Papers, was maintained throughout the policy process, even though it was acknowledged that this figure is a rough estimate. Extrapolating this cost forward to 2021 values gives us a cost of R415.2bn, which represents a shortfall against the 2021/22 national health budget (R248.8bn) of R166.4bn or 3.2% of GDP. It is fiscally entirely unfeasible to raise this level of taxes.
- The intentionally weak governance framework outlined in the NHI Bill is a cause for major concern. There is a concentration of authority in the hands of the Minister of Health to make

⁷⁰ National DoH, 2011

⁷¹ In 2011 prices

a wide range of appointments on the various sub-committees within the NHIF. There is poor oversight of this authority with minimal check and balances on decisions which, combined with the centralised and monopolised nature of the NHI proposal, makes this even more disconcerting.

In its current form, the NHI proposal is set to establish the largest State-Owned Entity (SOE), dwarfing the current largest SOE, Eskom, by comparison.

The state's very weak track record on appropriate and competent management of SOE's, with a preponderance towards corruption that feeds the now well-established patronage networks within the state, will be perpetuated under the proposed NHI governance framework (see Section 4.5), and lends no credence whatsoever to the state's verbalised aim of rooting out corruption.

4.2. NHI Socio-Economic Impact Assessment (SEIA)

As required by the Department of Planning, Monitoring and Evaluation (DPME), the DoH published a Socio-Economic Impact Assessment (SEIA) on the NHI Bill in July 2017⁷².

The SEIA Guidelines published by the DPME provide the framework and purpose of a SEIA. This SEIA is the '*initial impact assessment*' of the NHI, whereafter the DPME requires a '*final impact assessment*' at a later stage.

The guidelines explicitly outline a SEIA's functions - to '*minimise unintended consequences from policy initiatives, regulations and legislation*' and to '*anticipate implementation risks and encourage measures to mitigate them*'.

More specifically, it states that '*a more in-depth analysis and broader consultation with stakeholders should be undertaken for proposals where the **initial assessment** [author's own emphasis] suggests there will be substantial implementation costs, compliance costs, outcomes, risks or political sensitivity*'.

This initial impact NHI SEIA fails to evaluate these five basic requirements, meaning the SEIA fails to address the essential purpose of undertaking it. These failures could lead to significant unintended consequences – a cornerstone of what SEIA's explicitly attempt to avoid.

Outlined below is the NHI SEIA problem statement:

"The South African Government is committed to the goal of universal health coverage (UHC). However, to date, progress toward this goal has been limited by the existing health financing system structure".

This fails to provide a coherent characterisation of the problem statement. By narrowly defining the financing system as the singular impediment to the achievement of UHC, clearly not only ignores the fact that SA does not have a UHC coverage problem, but it also exemplifies a poor understanding of the diverse areas of specialisation, skill and management required in improving healthcare systems.

The fact that no technical costing analysis of the NHI proposal has been undertaken at any stage during the policy process means that the SEIA cannot quantify the macroeconomic consequences of the NHI

⁷² Department of Planning, Monitoring & Evaluation, SEIA (July 2017). Initial Impact Assessment: NHI Fund

proposal. Yet, paradoxically, in defining the problem statement, government provides as the problem statement ‘*the existing health financing structure*’.

Given that the basic cost estimate provided in the 2011 Green Paper (R415.3bn in 2021 prices) would amount to nearly a third of all current government expenditure, it is difficult to comprehend how no technical costing analysis was performed during the 10-year long policy process, yet the health financing structure is relied upon as the primary problem that this policy seeks to address.

The problem statement describes the “*existing health financing system structure*” as the impediment but, throughout the policy process, government has clearly described a ‘lack of funding’ as the main problem. It would then be necessary to understand to what extent there is a lack of funding, which would then guide the policy process to an understanding of how much additional funding is necessary to fulfil the proposal objectives, or at least how comprehensive the basket of services could be within existing funding levels.

Neither of these two critical points have been evaluated, hence the SEIA objectives are unfulfilled.

Much evidence also exists that South Africa already achieves universal health coverage. The International Labour Organisation World Social Protection Report of 2017⁷³ found no coverage gaps in South Africa, either from an inability to pay for services or a lack of access. A report⁷⁴ produced jointly by the World Bank and World Health Organisation (WHO) accorded South Africa a service coverage index of 0.67, a high rating for a developing economy. Corroborating this, the following is a statement on universal health coverage from the HMI⁷⁵:

“South Africa already provides near-universal access to healthcare to its citizens through a combination of publicly available services and in regulated private markets. However, it is generally accepted that publicly available services are not always of sufficient quality to be effective”.

The last sentence of the above quote from the HMI is what should have been the primary problem statement in the NHI SEIA. However, throughout the policy proposal there has been an avoidance in discussing quality failures in the public sector, with an underlying inference that more funding will automatically resolve quality matters.

Another requirement of a SEIA is to evaluate alternatives to the preferred proposal. This NHI SEIA provides two:

- Maintenance of the status quo, or
- Complete privatisation of all healthcare assets in the country.

This is an implausibly brief set of alternatives. The first implies that it is not possible to improve upon the existing health assets that the country possesses, which displays ideologically obtuse thinking. The state spent nearly R200m over 6 years on the Health Market Inquiry (HMI), which provided sound, evidence-based proposals for improving affordability and competition within the private sector.

The second alternative, complete privatisation of all healthcare assets in the country, is also self-evidently a highly improbable and implausible alternative.

⁷³ International Labour Office, 2017.

⁷⁴ Tracking Universal Health Coverage: 2017 Global Monitoring Report

⁷⁵ HMI, Provisional Report, 5 July 2018.

As was postulated in the White Papers of 2015 and 2017, the SEIA echoed the false sentiment that the current health financing system “punishes the poor”.

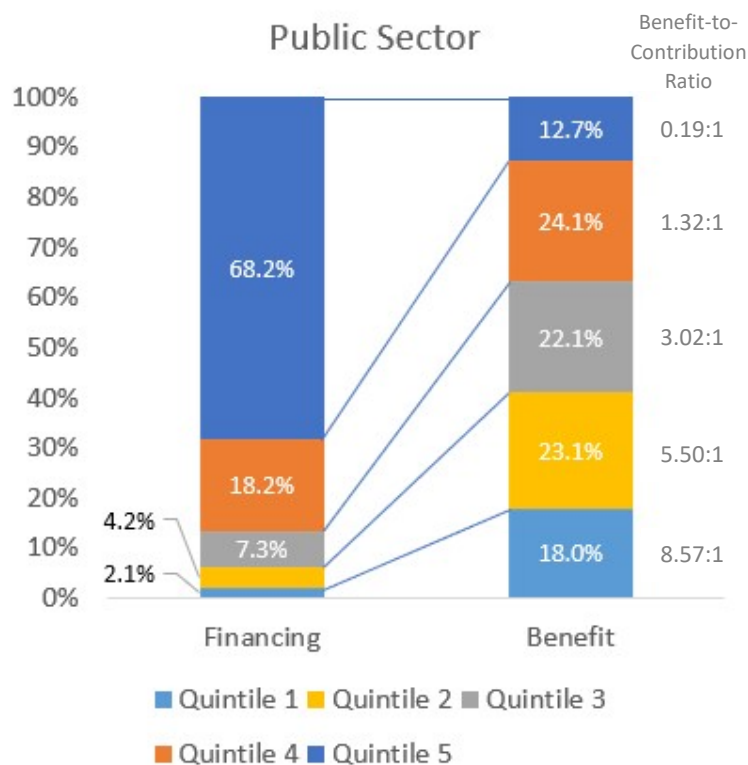
Graph 15 below is an analysis by Econex of the public sector financing and benefits received by the citizens within five equal income quintiles⁷⁶.

The public health sector is financed predominantly by wealthier citizens in quintiles 4 and 5 - who contribute 86.4% towards its financing - and receive slightly less than 37% of public sector benefits.

The poorest citizens, in quintiles 1 and 2, receive 41.1% of public sector benefits while contributing 6.3% towards its financing. The ‘Benefit-to-Contribution ratios shown on the right side of Graph 15 indicate that the poorest quintile receives benefits that are 8.57 times more than their contribution and the wealthiest quintile receives benefits that are less than one-fifth of their contribution. Of all the quintiles, only the wealthiest quintile (5) receives less benefits than they contribute.

This is a situation consistent with the healthcare principle of social solidarity, where higher income earners subsidise lower income earners, and cannot by any measure be considered a system that ‘punishes the poor’.

Graph 15



Finally, as we discussed above, it is unclear what services will be provided free-of-charge under the NHI and what services will need to be procured out-of-pocket or via medical schemes.

⁷⁶ Econex, Research Note 45, July 2017 (The population is ranked according to per capita household expenditure and divided into five equally sized groups (quintiles): the poorest 20% of the population fall into quintile 1 and the wealthiest 20% of the population fall into quintile 5.

Without a clearly delineated basket of NHI services and an equally clear understanding of costs, the macroeconomic and fiscal consequences of implementing NHI remain unknown but may ultimately be financially catastrophic for the country, given the magnitude of the proposals.

4.3. Financial Liability of the NHI

As we have discussed above, the NHI proposal is based on a government administered, centrally controlled, monopoly single-payer model which places the liability for the financing of healthcare for all citizens on the state. This is an intentional liability shift of the healthcare costs of the ±9 million citizens currently on private medical scheme cover onto the state.

This is an increase in the state's overall liability rather than a decrease therein.

Considering the currently parlous condition of state finances, it cannot be rationally explained why the state should implement a policy that is intentionally adding to its liabilities. Even beyond the consideration of state finances, it is irrational to reduce the per capita health budget allocation by forcing citizens out of their private arrangements and onto the state.

This is even more irrational when considering that the ±9 million citizens on medical schemes 'voluntarily' purchase their cover.

The creation of a monopolised single-payer system, such as the NHI is proposing will have the following impact on tax revenue or subsidies for the state:

- We showed in Section 2.4.1 how participation by the ±9m citizens on medical schemes subsidises the state's public health expenditure by R32bn annually.
- The reduced revenue from removed private health sector activities will amount to many more billions in lost tax revenue for the state (Section 2.4.3).
- The monopolised nature of the NHI will also mean that the current subsidy that the state receives on purchasing consumables and medicines will be lost (Section 2.4.4).

Other matters that are increasing the state's liability are the massive rise in the medico-legal liability arising from the poor quality health outcomes (see Section 2.5 above).

There appears to be no regard for the state's financial liabilities - this reflects in the SEIA, statements made in the policy process and the disregard for critical technical issues such as those listed above.

Written in the NHI white paper of 2015, the DoH selectively quotes below from the World Health Organisation (WHO), implying that the WHO is declaring cost as unimportant in health policy decisions:

"Focusing on the question of what will NHI cost is the wrong approach, as it is better to frame the question around the implications of different scenarios for implementing reforms towards achieving UHC."

This selective statement by the DoH is insightful for two reasons.

Firstly, on the matter of different scenarios, the policy process has not performed any feasibility assessments on 'different scenarios' – the NHI has steadfastly remained the only policy choice, as is demonstrated in the SEIA assessment outlined in Section 4.2.

On the second point of cost, what the WHO has additionally said on this matter is:

*“Ultimately, what UHC will cost depends **critically** [author’s own emphasis] on how it is designed and implemented. In that sense, looking at costing scenarios and assumptions may be valuable for raising some **core policy issues**.” [author’s own emphasis]*

The DoH is quoted in the 2015 white paper:

*“NHI represents a **substantial policy shift** [author’s own emphasis] that will necessitate a massive reorganisation of the current health care system.”*

The DoH is thus being disingenuous by suggesting that the WHO is dismissive of costs in achieving UHC.

Quite the opposite, the WHO states that what UHC will cost ‘depends critically on how it is designed and implemented’. The WHO states further that undertaking a costing analysis is valuable in assessing core policy issues - and there can be no doubt in anyone’s mind that the NHI Bill represents a very substantial policy change.

Independent economics consultancy Econex published commentary⁷⁷ on the funding aspects outlined in the 2015 White Paper and these were some of their findings:

“The funding shortfall in the White Paper is estimated at R 108 billion by 2025/26, assuming a GDP growth rate of 2%. Revised estimates, assuming greater increases in demand and updated GDP growth forecasts, indicate that the shortfall may exceed R 200 billion by 2025/26.”

“Given the literature on insurance induced demand, pent-up demand and South Africa’s unique quadruple burden of disease, much larger utilisation increases are to be expected than current assumptions allow for. The expected increases in demand and utilisation associated with the introduction of the NHI are not sufficient.”

“Expected increases in both demand and supply are therefore not adequately accounted for in the NHI White Paper costing model. It implies that the financial implications of the NHI will be even greater than currently anticipated.”

Similar to South Africa’s policy process, the Republic of Ireland published a Universal Healthcare Insurance White Paper in 2011 without undertaking any costing of the proposal or defining the basket of services that would be offered.

In 2015, following costings and analysis from the Economic and Social Research Institute (ESRI), the study showed that the Irish Government’s proposed model “is not affordable now or ever”. The proposal was subsequently abandoned by the Irish government.

Nonetheless, it proved a vote winner in Ireland’s 2011 general election. However, the party’s failure to cost its own proposals then, and the Government’s subsequent failure to do so until 2015, represented the “outstanding policy failure of the Coalition administration”⁷⁸.

⁷⁷ Econex, Comments on select aspects of the NHI White Paper, June 2016 (Prof Nicola Theron, et al)

⁷⁸ Irish Times. “An outstanding policy failure on universal health insurance”. 23 November 2015

4.4. Nationalisation of Private Sector Providers

There remain some contradictions within the NHI Bill around what form medical schemes will take. Section 33 of the Bill, reads as follows:

Role of medical schemes

33. Once National Health Insurance has been fully implemented as determined by the Minister through regulations in the Gazette, medical schemes may only offer complementary cover to services not reimbursable by the Fund.

This indicates that medical schemes may not offer cover for services that the NHI will provide. However, Section 8 of the Bill states:

Cost coverage

8. (1) A user of the Fund is entitled to receive the health care services purchased on his or her behalf by the Fund from an accredited health care service provider or health establishment free at the point of care.

(2) A person or user, as the case may be, must pay for health care services rendered directly, through a voluntary medical insurance scheme or through any other private insurance scheme, if that person or user—

(a) is not entitled to health care services purchased by the Fund in terms of the provisions of this Act;

(b) fails to comply with referral pathways prescribed by a health care service provider or health establishment;

Clause (2)(b) above implies that if a user fails (i.e., chooses not) to comply with NHI referral pathways that they must pay for their health care services through their own insurance. It is somewhat puzzling that they do not refer to a medical scheme in this section but rather to a 'medical insurance scheme', an entity which does not exist in SA.

Nonetheless, regardless of the contradictions outlined here, it is generally accepted that the intent is for the NHI proposals to provide cover for all citizens, thereby excluding medical schemes from being able to cover services delivered by the NHI.

This is known as a Complementary Single-Payer Model (CSPM), but it is worth noting that only five countries⁷⁹ have built a CSPM and only one of those countries is a developing economy, namely Cuba.

As we noted in Section 2.1.2, the NHI proposal has largely been modelled on the Cuban nationalised health system.

A CSPM is the most expensive form of any national health system, as the government assumes exclusive liability for the provision of health care services for the entire nation, even those who are willing and able to pay for their own private health care provision. As noted in Section 2.1.2, Cuba spends 13.4% of GDP on healthcare, by far the most for any developing economy and certainly amongst the highest when compared with developed economies.

⁷⁹ Britain, Canada, Estonia, Taiwan & Cuba

Another feature of a CSPM is that it establishes a legislated monopoly, and there is no doubt that the overriding characterisation of all monopolies are inefficiencies and high costs. The lengthy patient waiting periods in the UK and Canada are the well-known examples of such monopoly systems. The quote below from Michael Porter, Professor of Economics at Harvard University, is incisive on the matter of monopolies:

“But history tells us that monopolies that are truly benevolent and effective are rare.”
– Michael E. Porter, Redefining Health Care: Creating Value-Based Competition on Results

The complementary nature of the NHI proposal will have the effect of nationalising private sector providers and dramatically limit the role of medical schemes.

This will have a remarkable impact on the private sector, as most private sector providers are currently reimbursed for their services via medical schemes. This complementary nature of the NHI and depending on what services will be included in the NHI’s basket of care, means that many private sector providers will be forced to contract with the NHI Fund, as this will be their only source of revenue.

Professional fees for private sector providers are currently not regulated, providing relative scope for these providers to set their own prices that market conditions will accept.

Through the Health Care Benefits Pricing Committee of the NHI⁸⁰, prices will be set for providers for their services delivered under the NHI. This means that not only will the NHI compel providers to work for the NHI, but it will also dictate their remuneration levels.

Many private providers will resent the coercive nature of these proposals, with many indicating that they are prepared to emigrate or change their vocation under these circumstances⁸¹.

When Cuba established its nationalised health system, it forced all private service providers into contracting with it. This resulted in a mass exodus from the country of about one-third of all medical personnel - in the ensuing decade, health outcomes across many metrics substantially worsened in Cuba⁸².

Any failure to adhere to a realistic and fair process on establishing provider remuneration levels will have significant consequences on the availability of healthcare providers in South Africa.

The monopoly nature of the fund, along with its overtly centralised governance and management structure, also stands in stark contrast to international best practice of decentralising health systems⁸³, where doctors have greater autonomy in the scope of treatment they provide to their local communities.

The NHI proposals are largely based on consolidating the public and private sectors into one health system, with the view that this will resolve funding and provider shortages.

⁸⁰ Section 26 of the NHI Bill

⁸¹ <https://businesstech.co.za/news/lifestyle/364206/nhi-would-force-40-of-doctors-to-leave-south-africa/>

⁸² An Evaluation of Four Decades of Cuban Healthcare, Felipe Eduardo Sixto, 2002

⁸³ See Section 4.6 – Deficits of Centralisation

In terms of addressing provider shortages, the opposite is more likely to occur as this proposal is not fundamentally addressing the cause of shortages and is likely to cause an exodus of medical personnel.

Only public universities can train doctors in SA, and the country is limited to producing around 1,200 - 1,300 medical graduates annually, a figure woefully inadequate for our population⁸⁴.

It remains anomalous that the SA government steadfastly refuses to permit private universities and the private sector to train doctors as a means to increase the number of medical graduates. Many countries see this as a solution to addressing provider shortages. A study from The Lancet⁸⁵ is quoted on the issue of addressing health worker shortages:

“The shortage of health workers is a global challenge, countries need to rethink traditional models of health worker education and their deployment in service delivery.”

4.5. NHI Governance Structure

The governance framework outlined in the NHI Bill confers substantial, concentrated and unchecked authority to the Minister of Health (MoH).

Board members of the NHI are all appointed by the MoH through an ad hoc committee, which is also appointed by the MoH, who will conduct interviews of candidates and make recommendations to the MoH for final approval. The MoH also has sole discretion on the appointment of the Board chairperson and deputy chairperson and removal of any Board member⁸⁶.

Remuneration of Board members is also at the behest of the MoH. The Board will conduct interviews for the appointment of the CEO of the NHI Fund but the MoH will make the final appointment⁸⁷. The following excerpts from the NHI Bill exemplify the significant amount of authority that the MoH will possess:

*“The Fund, in consultation with the **Minister**, must purchase health care services, determined by the Benefits Advisory Committee ...”*

Section 4(1)

*“Subject to the provisions of this Act, the Fund, in consultation with the **Minister**, must purchase health care services, determined by the Benefits Advisory Committee, for the benefit of users.”*

Section 7(1)

*“Treatment must not be funded if a health care service provider demonstrates that— ... the health care product or treatment is not included in the Formulary, except in circumstances where a complementary list has been approved by the **Minister**.”*

Section 7(4)(c)

*“The Fund performs its functions in accordance with health policies approved by the **Minister**.”*

Section 10(3)

⁸⁴ From Brain Drain to Brain Gain, Mahlathi and Dlamini, African Institute of Health & Leadership Development, 2017

⁸⁵ Moving towards universal health coverage, (Reich, et al) The Lancet, 2016

⁸⁶ Section 13 of the NHI Bill (page 13)

⁸⁷ Section 15 of the NHI Bill (page 14)

*“identify, develop, promote and facilitate the implementation of best practices in respect of— ... the design of the health care service benefits to be purchased by the Fund, in consultation with the **Minister** ...”*

Section 11(1)(vii)

*“identify, develop, promote and facilitate the implementation of best practices in respect of— ... referral networks in respect of users, in consultation with the **Minister** ...”*

Section 11(1)(viii)

*“(1) The Board, in consultation with the **Minister**, must establish an Office of Health Products Procurement which sets parameters for the public procurement of health related products. (2) The Office of Health Products Procurement must be located within the Fund and is responsible for the centralised facilitation and coordination of functions related to the public procurement of health related products, including but not limited to medicines, medical devices and equipment.”*

Section 38

*“The Fund, in consultation with the **Minister**, must determine the nature of provider payment mechanisms and adopt additional mechanisms.”*

Section 41(1)

It is clear from the above overview that the corporate governance model for the NHIF is politically motivated.

All appointments to the board and the CEO are directly or indirectly made by the MoH, whilst simultaneously extensive executive authority is conferred onto the MoH.

It is also worth noting that the MoH also appoints the board and executive of the Office of Health Standards Compliance, the body responsible for accrediting health providers. Providers who do not receive accreditation will not be able to contract with the NHIF.

Such concentrated and absolute authority, with little to no oversight, is deeply concerning.

4.6. Deficits of Centralisation

It would be no exaggeration to say that Britain’s National Health Service (NHS) is often referred to as the benchmark for countries wanting to establish their own national health system.

South Africa’s previous Minister of Health, Dr Motsoaledi, routinely proffered the supposed success of the NHS to critics when questioned about NHI. However, British euphoria created around the NHS often involves substantial technical inaccuracies on its clinical achievements and patriotic hysteria that any alternative proposal to the NHS means a move to an American style healthcare system.

The American health market is a unique outlier in the world, thus making any comparative reference to it superfluous. Nonetheless, in a rhetorical sense it is an easy target to reference against because of its multiple and costly failures. This is relevant here because often protagonists of national healthcare systems, and the SA government especially, only have two varieties of healthcare systems in mind – either entirely nationalised or entirely private.

This ideological trap was in clear evidence in the NHI SEIA outlined in Section 4.2 above.

The truth is that the vast majority of healthcare systems around the world which achieve universal coverage are a healthy blend of competing private and public providers and funders. Furthermore, the funding mechanisms are a combination of out-of-pocket spend, privately pre-funded contributions and tax funded healthcare.

It is also not a pre-condition to have free access or for the state to be the single procurer or funder. If the state and/or private funders can procure from either public and/or private providers in competition with each other, inevitably, these competitive market forces bring about cost efficiencies and outcome improvements that no monopolised national health system can compete with.

Approximately 75% of Brazil's citizens are covered by the public sector, with the remaining 25% covered in the private sector. However, the public system purchases care from a mix of public and private providers, as do private sector funders. An estimated 56% of funding comes from private pre-paid or out-of-pocket expenditure.

The Netherlands achieves universal health coverage, but its government owns neither a single health facility nor health insurer. In Germany 60% of hospital beds are privately owned.

It is how the two sectors, private and public, are blended under workable and coherent policy frameworks that determines the relative success or failure in achieving the overarching objective of quality care that is universal.

In this section we focus on how reforms to the NHS provide evidence that decentralisation improved outcomes and patient satisfaction.

NHS Reforms of the early 1990s⁸⁸

Prior to the 1990's, the NHS was practically a single State-Owned Entity. To bring about typical market forces of a free market economy, a new reform in the early 1990's introduced a separation of the funding and provision of care. Funders were split up into the District Health Authorities (DHA) and hospitals separated into their own legal entities called NHS Trusts (Trusts). DHA's had to actively seek out contracts with the Trusts and, conversely, Trusts had to compete for services.

By normal market comparisons it was not a resounding success, but this reform did bring about positive changes necessary to eradicate some inefficiencies that existed within the NHS because of its original structure. The two broad prior monopoly components were in funding and delivery and after this reform, both the DHAs and the Trusts had to focus more on consumer choices and patient outcomes. A research study on the NHS in 2007 was quoted as:

"The general criticism of centralised control is that the "central planners" will lack knowledge of local conditions, especially the type of knowledge that cannot easily be expressed in numbers or even words ('tacit knowledge'). The British experience with centralised performance management of the [NHS] health service amply illustrates the validity of this criticism."

Central control, typical of these sorts of monopolised health systems, can be likened to the central control theories of Marx and Lenin that were implemented by the Soviet Union ('Gosplan' being the USSR's central control planning unit). Gosplan tried to control everything from supply, to demand, to quality and type of service.

⁸⁸ Sources below in this section are from Kristian Niemietz, "Universal Healthcare without the NHS", 2016 (Institute of Economic Affairs)

The failure of Gosplan, and similar centrist systems, are documented broadly enough that duplicative criticisms here are needless but what does remain a mystery is why any modern-day government would want to replicate such a universally failed system.

The NHI proposes creating a national, monopolised single payer health system for SA that will from centralised committees dictate service levels, reimbursement levels, extent and type of care and accreditation of providers.

This is precisely what should be avoided rather than duplicated. The second major reform within the NHS is highly informative on this point.

NHS reforms of 2002

From around 2002, another reform was brought into the NHS – patient choice. This was introduced gradually over time and at various levels of care, but the effect was obvious and substantial. Previously, limited choice of providers for NHS patients meant that providers only competed between themselves for contracts with the local DHA (this is akin to one part of the NHI proposals, where providers will seek to be accredited by the NHI, i.e. their only competition will be other providers seeking to get accredited).

Now NHS providers had to compete more for patients rather than for DHA contracts. After funding rules and reimbursement mechanisms were changed so that money followed patients, the Trusts became focused on attracting patients. Waiting times reduced, patient satisfaction surveys became all important metrics and, critically, clinical outcomes improved.

Provider structures were fundamentally altered to become less centralised, with more integrated care units being established around patient needs and achieving better outcomes. Since DHAs could now fund any patient at any Trust, even they had to improve their services in order to retain patients.

Summary of NHS

In summary of this section, the points we have made here is that although the NHS is often touted as being the benchmark for nationally run, monopolised single payer health systems, in practice it no longer operates in this manner. While the overall funding of the NHS is derived primarily from a single source (i.e., dedicated and general taxes) it can be regarded as being a multi-payer and multi-provider system, with the DHAs and Trusts having to compete with each other for patients.

The simple but powerful free-market principles achieved were:

- Member choice of insurer meant that funding followed the chosen funder (DHA), and
- Patient choice of provider meant that reimbursement for care followed the chosen provider.

The only way this can be achieved is to not have a single payer system and ensure that providers compete for patients on the basis of clinical outcomes and funders compete for members on the basis of quality and efficient service. The NHS is by no means a totally free market system, since any failed DHA or even Trust will be bailed out by government, and it still lags its European counterparts in terms of outcomes. Nonetheless, the NHS has shown the most improvement in outcomes over the past three decades when compared to its peers and its metamorphosis represents a substantial departure from what is often touted, incorrectly, as being a true single payer monopoly system.

These changes were initially politically foisted upon the British government, compelled to bring about the necessary changes to the way the NHS was structured to contain costs, improve outcomes and essentially meet the needs of British citizens.

SA is now embarking on the road of a monopolised single payer system, much like the NHS did in 1948. The NHS experience has shown that monopolised, centrally controlled structures are inherently weak systems, suffering from the typical problems that all monopolies suffer from – growing costs, declining quality and an unmanageable monolithic bureaucracy.

It would be prudent for SA to consider leveraging off the substantial skills that exist within the private sector to deploy a multi-payer system with funders competing for members, similar to what the NHS has now implemented.

Similarly, a structure where providers compete for patients on the basis of measured and publicised quality outcomes⁸⁹ and patient satisfaction would be more economical and clinically effective than the deployment of a massive army of inspectors through the OHSC.

A note on NHS Measurement – another critical aspect of the NHS for SA to bear in mind is that of creating a quality measure of clinical outcomes. Tied together with providers competing for patients, it becomes an essential tool in maintaining the competition between providers and giving patients the ability to choose providers based on their outcomes (as opposed to where they were regionally contracted to the NHS prior to the reforms outlined herein).

The HMI did recommend the establishment of an entity to undertake outcomes measurement in SA's private sector (Section 3.2 above). There is no reason this should not be extended to a measure of public sector outcomes.

In closing this section, consider the following commentary from 2015 by Nassim Nicholas Taleb, an essayist, scholar, statistician and risk analyst. Author of the *Incerto - The Black Swan*, *Foiled by Randomness*, and *Antifragile*, a multivolume philosophical essay on uncertainty and risk - Taleb is considered to be one of the globe's foremost thinkers on risk management:

"We have lived since modernity under the illusion that centralisation is better, more 'efficient', that the large works better than the small, and that the reduction of the numbers of decision-makers improves stability.

However, centralisation, while making systems less noisy, causes them to be less opportunistic, less capable of changing direction, and worsens their performance at times of crisis. In fact, government decentralisation would help reduce public deficits.

Large public projects, under the myth of costs savings, appear to incur disproportionately large costs overruns. Size produces visible benefits but also hidden risks; it increases exposure to large losses⁹⁰.

This [My] wish translates into a principle of maximal effective diversification and decentralisation, which, when applied to administrations, is similar to that of 'subsidiarity', which helped the Catholic Church survive two millennia.

Nothing in a hierarchy should be done at a higher level if it can be effectively managed at a lower one. The principle does not mean that some things should not be centralised: the military, for example, cannot be effectively decentralised, except for guerrilla warfare.

⁸⁹ The HMI recommended the establishment of a body to undertake measurement of outcomes (See Section 3.2)

⁹⁰ Author's Note: This paragraph perfectly sums up two similar major financial catastrophes at Eskom, namely the construction of the Medupi and Kusile power stations. Both are years behind schedule and each have incurred cost overruns of many billions of Rands.

Compare canton-based decision making in Switzerland or the federal system in Germany to the centralised regimes in Soviet Russia and Baathist Iraq and Syria. In fact, historically, both Pharaonic Egypt and Imperial China achieved success prior to the centralisation around scribes and scholars, not after, when they fell apart. The Roman empire, on the other hand, was maximally decentralised.

The distribution of decisions and projects across as many units as reasonable reinforces the system by spreading errors. Uniformity is risky: while, for instance, monoculture seems more efficient and a more stable form of agriculture, such concentration makes the system more prone to consequential trauma, “Black Swans” such as the Irish potato famine of the 19th Century. Oil-dependent countries such as Saudi Arabia and Venezuela are currently getting a crash course on that.”

4.7. International Comparisons

In this section we examine at a high level the healthcare systems of four developing economies, with reference to their mix of private and public funding and their various sources of that funding.

In Table 10 we see a comparison of high level national financial indicators for the countries⁹¹ compared with SA. The average Tax Base for these four countries is 29.5% versus that of 10.4% for South Africa. Their average unemployment level is 3.8% versus 25.4% for South Africa⁹².

Table 10

2014	Population	Taxpayers	Tax Base	Unemployment	GINI
Mexico	122.3	46.3	37.9%	4.8%	48.1
Thailand	68.0	20.0	29.4%	0.9%	39.3
Brazil	202.0	50.5	25.0%	6.8%	52.9
S Korea	49.0	13.5	27.6%	2.7%	31.3
Average	110.3	32.6	29.5%	3.8%	42.9
RSA	55.0	5.7	10.4%	25.4%	63.4

In contrasting how these countries fund their national health systems and the blend of private and public providers, the following are insightful observations:

- In Mexico⁹³ the split of total expenditure between their private and public sectors is 52:48.
- Out-of-pocket payments on healthcare costs in Mexico constitute ±40% of total spend⁹⁴.
- Thailand has 1,290 hospitals, of which 28% are privately owned⁹⁵, and 35,383 community clinics of which 72.4% are privately owned.
- Health expenditure in Thailand is split about 35:65 between private and public sources⁹⁶.

⁹¹ Submission on Draft NHI Bill, SA Private Practitioners Forum (Sep 2018)

⁹² South Africa's tax base has shrunk and the unemployment rate has worsened with the advent of the Covid-19 pandemic

⁹³ “Reflections on public-private participation in healthcare.” Carvalho, et al (2014)

⁹⁴ Health in the Americas, Pan American Health Organization (2017)

⁹⁵ Thailand: Sustaining Health Protection for All, World Bank 2012

⁹⁶ Thailand: Sustaining Health Protection for All, World Bank 2012

- Brazil has the World's largest public health system covering 75% of citizens (\pm 155m), yet the Brazilian government still provides tax incentives to private sector providers to encourage growth of the private sector, currently covering about 25% of citizens⁹⁷.
- Of Brazil's 485,000 hospital beds, 70% are privately owned but deliver care to both privately and publicly insured citizens⁹⁸. This gives Brazil a hospital bed density ratio of 24.0 beds per 10,000 population, which is equal to what SA's *public sector* hospital bed density was in 2003 (see Section 2.3).
- South Korea's NHI is funded through a payroll tax equal to 10.2% (5.1% each for employer and employee) yet it still has substantial user co-payments for health care services (10%-20% for in-hospital services and 30-50% for out-patient services)⁹⁹.

The brief analysis above exemplifies a few points that are pertinent to the NHI policy proposal. Whilst each of the four countries above have tax bases that are significantly better than South Africa's, they still have a significant private health sector.

Also, converse to the NHI promise of free healthcare for all, the countries above all deploy various forms of user co-payments to partially fund the overall healthcare costs and manage utilisation.

Free comprehensive healthcare for all, as the NHI proposes, is a utopian dream that not even the wealthiest countries are able to attain.

Creating a robust and coherent regulatory framework for the private sector, as has already been proposed by the HMI, will ensure that the private sector is affordable to more citizens.

This creates a symbiotic relationship, whereby an expanding and affordable private sector directly and significantly improves the public sector per capita budget.

⁹⁷ https://en.wikipedia.org/wiki/Healthcare_in_Brazil#cite_note-3

⁹⁸ Brazil Ministry of Health; Registry of healthcare facilities and their installations (2014)

⁹⁹ Lee, J-C. "Health Care Reform in South Korea: Success or Failure" American Journal of Public Health

5. Alternatives

5.1. A ‘Health Market Inquiry’ for the Public Sector

The public sector is unlikely to be repaired unless an extensive and detailed assessment is undertaken, by an independent entity, of the extensive problems currently afflicting it. It is clear that these difficulties are pervasive and complex and intrinsically intertwined with the practice of cadre deployment and the resultant patronage networks and corruption that has beset the country.

The public health sector is a substantial national asset, but it has unfortunately deteriorated in quality and capacity over the past two decades. This is despite having received a budget that has doubled in real, per capita terms over this period and now employs 42% more medical personnel than it did in 2006.

Imposing the NHI on a dysfunctional public health sector will only serve to destroy its capacity to deliver care rather than enhance it.

An incremental process of improving quality and outcomes will be much more manageable, where assessments within the existing organisational and governance frameworks can be undertaken, with a view to improving it gradually with controllable yet meaningful changes.

The policy process that the NHI proposal has followed has heavily focused on a supposed lack of financial resources as being the primary impediment to attaining quality universal healthcare.

However, as we have detailed in this report, neither financial nor human resources have been lacking, despite the government’s policy process inaccurately relying on this as the problem statement throughout the 10-year long NHI policy process.

This inaccuracy would be rectified by the appointment of an equivalent independent body to investigate the public health sector, as the HMI was for the private sector. Not only would this investigation serve to rectify the inaccuracies in the policy process, but it would also honestly outline in more detail how and where the public sector could realistically improve without suddenly and dramatically upending its basic structures.

The SA Health Review article referenced in Section 2.5¹⁰⁰ as well as the OHSC’s latest report (2018/19) highlighted that a lack of governance and leadership are major problems affecting the public health department and that unless these problems are rectified, the attainment of quality health care provision is highly unlikely.

We fully concur with this view and believe that improving governance and re-establishing accountability through the appointing of qualified and non-politically connected individuals into key positions will garner substantial improvements in outcomes – and, importantly, within the existing public sector budget levels.

The matter of unskilled public servants deployed into public departments and SOE¹⁰¹ has received some attention recently, resulting from testimonies at the Zondo Commission.

¹⁰⁰ SA Health Review 2019 (Achieving high-quality and accountable universal health coverage in South Africa, Rispel, et al)

¹⁰¹ State-Owned Enterprises

An article¹⁰² by Business Day Editor, Carol Paton, outlines the dysfunction that results from this practice:

“While the Zondo commission on state capture cannot bring us convictions of the corrupt, it has brought many other great things. Among the best and most important was the light shone into the black box of the ANC’s deployment policy over the past week. There is no other single factor that is as responsible for the ANC’s failure to govern effectively over the past 25 years. The deployment of cadres has hollowed out the state and all its key institutions of expertise and objectivity, it has opened the door to corruption on a grand scale in state-owned enterprises, and it has collapsed the distinction between party and state and provided cover for widespread looting, from the highest political office in the land to the smallest town and municipality.”

At the time of writing, President Cyril Ramaphosa has spoken of establishing a SOE Council that will improve governance and oversee appointment processes and the strengthening of the Public Service Council, in order to implement a new role in oversight of appointments of senior national and provincial officials¹⁰³.

Assuming that these actions are able to achieve the necessary reform and reinstate qualified and honest officials into key positions within the DoH, an independent inquiry into the public sector may be moot.

However, the stated action by President Ramaphosa acknowledges the view that the state’s long time practice of cadre deployment of unqualified and politically connected individuals into various public sector positions of influence and power, are recognised as directly causal to the lack of proper leadership and adherence to good governance practices which has hollowed out the state’s expertise and skill.

The litany of information that has been made public through the testimonies at the Zondo Commission, as well as various work by investigative journalists and civil society bodies, are steadily forcing the government to face the harsh reality that State Capture, and all the malfeasance that it encompasses, has severely impacted service delivery at virtually every level of public service.

The health department may very well be one of the most severely harmed of all public services.

5.2. Private Sector

5.2.1. Converting the Medical Tax Credit

The LCBO¹⁰⁴ package that the CMS are currently developing will aim to provide a basket of primary care services, covered by medical schemes, that lower income earners can access.

Given that these products already exist in the market in the form of insurance products, it is possible to gauge the level of demand that there would be for such a product. According to the CMS¹⁰⁵, there

¹⁰² <https://www.businesslive.co.za/bd/opinion/columnists/2021-04-19-carol-paton-anc-deployment-at-heart-of-its-failure-to-govern-sa/>

¹⁰³ <https://www.businesslive.co.za/bd/opinion/columnists/2021-04-29-anthony-butler-at-best-cadre-deployment-was-a-transitional-instrument-whose-time-has-passed/>

¹⁰⁴ Low Cost Benefit Option (LCBO); The CMS have two committees currently investigating development of the LCBO framework

¹⁰⁵ CMS Circular 82, 2019

are currently around 500,000 insurance policies providing low-cost cover similar to what the LCBO benefit package will be.

The current insurance products do not have data indicating what the income levels are of the members partaking in these products, but a market assessment of what sectors participate in these products broadly outlines two market segments. The first is a retail market of private individuals purchasing cover and the income and benefit levels in this segment are typically higher than the second market segment.

The second market segment constitutes employers purchasing cover on behalf of their employees. The income level of the employees and the product cost are typically much lower, although the basket of benefits provided is still reasonably similar to the retail market segment.

In this employer segment, employers usually either carry the full cost of the package or provide some level of subsidy with the employee carrying the balance thereof.

The members within both these market segments obtain no tax relief on their premiums since the current medical tax credit only applies to medical scheme members. Furthermore, once LCBO is developed within medical schemes and presuming that the medical tax credit will apply to these members too, those members participating in LCBO that are below the income tax threshold will obtain no tax relief.

Our view therefore is that a separate tax treatment should be created for LCBO members wherein an implicit subsidy, equal to the current medical tax credit, is provided to medical schemes from Treasury based on their numbers of LCBO members.

This subsidy would then be utilised by the medical scheme to subsidise the cost of delivering the LCBO option.

5.2.2. Mandatory Cover for Employed Citizens

As we noted in Section 3, the current Medical Schemes Act was meant to include mandatory coverage at its promulgation in 1998, since this is the protection mechanism against the anti-selection that occurs when social solidarity principles are applied without mandatory cover.

This has severely harmed the private sector, with costs rising well above inflation for the past two decades (See Section 3.1).

Unless the social solidarity principles are removed from the private sector regulatory framework, some form of mandatory coverage will be required in the private sector.

The HMI has fallen short of making this recommendation¹⁰⁶, believing that there are a number of other distortions in the private sector that would need to be rectified first before such a move should be made.

Whilst this may be a debatable perspective, the HMI agrees that mandatory coverage will ultimately be essential. Their recommendations are for a phased approach, starting with the highest income earners and incrementally adding lower income groups over time.

¹⁰⁶ Final Findings and Recommendations Report, HMI - September 2019 (Clause 271, page 240)

This should also be implemented along with a move towards use of income bands on medical scheme contribution tables. This will enhance the social solidarity principles, where higher income earners subsidise lower income earners.

In combination with the main regulatory thrust of the HMI recommendations, this incremental approach would be more manageable to implement and induce some cost efficiencies over time that would make the move to full mandatory coverage less disruptive to affected citizens.

Furthermore, depending upon whether LCBO is developed, mandatory cover could be applied in a similar incremental manner for LCBO products but obviously for a lower income segment.

5.2.3. VAT Exemption

As we noted earlier in Section 2.4.3, VAT was previously exempted from all private service providers charges.

One could argue that at least a basket of medical care can be considered as essential and thus should be exempted from VAT. The current VAT exemptions on certain basic foods have similar principles.

An exemption on all or at least a portion of primary care services, such as the proposed LCBO, would be considered as progressive. This could be applied to patients purchasing care on an out-of-pocket basis or to insured members covered on LCBO.

The current process under way to create a more affordable medical scheme package (LCBO) could be used as the benchmark for the exempted services.

6. Conclusion

This assessment of our national health assets and review of the NHI policy process is intended to achieve three outcomes in principle:

- Rectify the inaccuracies that have characterised the problem statements in the SEIA and those emanating from government officials during the policy process, and
- To outline that national health systems are typically complex, requiring co-operation between efficient and functioning private and public sectors, with both funded via various sources.
- To emphasise that centralising the control of procurement, clinical protocols and accreditation of providers is not only unnecessary, but it in fact also induces inefficiencies, raises costs and worsens outcomes.

The NHI policy process has been technically superficial, with an overt reliance on a lack of additional funding - specifically under government control - as being the singular impediment to delivering better health care.

Other problem statements relied upon by government throughout the policy process have also been technically inaccurate, such as declaring that SA does not have universal health coverage and that there is a human resource imbalance between the private and public sectors.

We have demonstrated in the historical expenditure analysis in Section 2.1.1, that public sector health expenditure has almost doubled in real per capita terms over the past 20 years. The analysis of international health expenditures in Section 2.1.2, also shows that SA's per capita public expenditure compares favourably with richer peer countries.

We have further shown that SA does achieve UHC, and we highlight that it is the quality of care, rather than its accessibility, that is the public sector crisis that requires urgent attention.

We also showed that the number of public sector medical personnel employed by the state grew by 42% between 2006 and 2016 and the state now employs approximately 75% of all medical personnel in the country.

The multitudinous failings in delivering quality care in the public sector is the result of widespread cadre deployment and rampant corruption that has stripped the public health department of skill and capacity. The resultant leadership vacuum and governance failings have also resulted in the accumulation of an enormous medical malpractice liability on the state's balance sheet.

Our analysis herein nullifies the 'lack-of-resources' argument put forward by government and correctly focuses on the need for the reinstatement of qualified and non-partisan officials into positions of management in the public health sector under greater levels of accountability.

The private sector has been provided with a blueprint via the HMI recommendations in order to improve efficiencies, promote better competition and reduce costs. This requires political will from government in order to implement the changes for the private sector to grow into a more substantial national asset, which directly confers substantial benefits to the public sector.

The NHI policy process was born in the heart of the State Capture era, where the overt focus on policy principles was to extend as much access to state resources as possible, with little consideration given to a competent public health service or an efficient private health sector.

It would be no exaggeration to claim that NHI was designed for the purpose of extending patronage through access to vastly greater public funds.

No matter how effective government may be in reinstating qualified, competent and non-politically connected individuals into the public health sector, the NHI's weak governance model, along with its monopolised and centralised nature, make it the perfect breeding ground for even more corruption and patronage.

It is our view that the NHI policy should be abandoned in its entirety with the establishment of new health policies that are founded through an inclusive and technically competent policy process.

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