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# The NHI Proposal
## Risking Lives For No Good Reason

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Patients waiting at Chris Hani Baragwanath Hospital in Soweto

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# SYNOPSIS

According to the White Paper on the proposed National Health Insurance (NHI) system, the NHI will 'provide universal access to quality, affordable health services', which will be free to all South Africans at the point of delivery. It will do so by pooling all health monies into a single new NHI Fund; drawing on both public and private health resources; introducing comprehensive price controls on fees, medicines, consumables, and the like; and giving the state control over all aspects of medical treatment, from the treatment protocols to be applied to the medicines to be prescribed and the diagnostic tests to be allowed.

The NHI will effectively put an end to private health care. The medical schemes that currently sustain private practice will mostly not survive once they are confined to providing cover 'complementary' to that supplied by the NHI. In addition, state controls will be so extensive that practitioners will have little autonomy in running their own practices.

The NHI will require a huge bureaucracy to implement. This will start with the NHI Fund, into which all health monies will be paid and from which all health expenses will be met. The NHI Fund will need eight sub-units to decide on NHI benefits; approve treatment protocols; set prices; accredit doctors and others; procure supplies; pay providers; monitor performance; and guard against fraud. In addition, there will be an NHI Commission (to oversee the NHI Fund) and a National Health Commission (to help deal with non-communicable 'lifestyle' diseases). Also necessary will be committees to decide on health technologies; approve health products; oversee some 3 900 public hospitals and clinics; run ward- and school-health programmes; deliver medicines and other supplies; monitor performance at district level; and maintain a data base with details of all health providers and some 55m patients. The Office of Health Standards Compliance (OHSC) will also need many more inspectors to review, on a four-yearly basis, some 3 900 public facilities and up to 74 000 private practices, so as to decide if they qualify for NHI accreditation (itself a further complex process dependent on assembling and analysing a host of demographic, epidemiological, and other data).

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The NHI White Paper assumes that centralised procurement and the state's price controls will lower health care costs. But, without a market mechanism to help determine needs, officials will have to decide what health services are to be provided, when, and where. This in itself will make for major inefficiency. Bureaucratic control will also stifle innovation and promote corruption, adding to overall costs.

The White Paper further assumes that all private health practitioners and facilities can successfully be drawn into the state-controlled NHI. However, it proposes paying the same capitation-based fees to both public and private practitioners, even though the latter have overhead expenses to meet which the former do not. Experience with the Compensation Fund also indicates that practitioners could wait months or years for the NHI Fund to reimburse them. This could encourage major emigration among professionals already in short supply.

The White Paper seems to believe that all private health care monies (R189bn in 2016/17) can successfully be diverted to the NHI Fund, giving it (if it were to start this year) an overall amount, together with health revenues of R183bn, of R372bn. This is also close to the minimum that would be needed to give 55m South Africans cover for some 300 prescribed minimum benefits (PMBs), at a current cost of R605 per person per month or R396bn a year. But many people now paying for the sound private medical care of their choice may not be willing to contribute the same amount to the NHI, under which health services are

likely to become tardy and often poor. This could fuel emigration among the 480 000 people who currently contribute some 57% of personal income tax. This would greatly erode South Africa's tiny tax base, making it harder to fund government spending in every sphere.

The White Paper further presumes that the revenue needed to fund the NHI will be limited to 6.2% of GDP in 2025 (when the system becomes fully operative). This figure rests on a flawed belief that the economy will grow by 3.5% of GDP a year between now and then. It also underestimates likely NHI costs, which are likely to start at R372bn a year, rather than the mooted R256bn. Moreover, since both public and private health spending, in nominal terms, has risen by some 45% over the past five years, annual NHI costs could rise, from R372bn at the start, to R539bn after five years and then to R782bn after another five years.

Such sums are unaffordable, especially with the growth rate so far down (at a projected 0.5% of GDP in 2016) and the government already battling to meet its funding needs. According to October's mini-budget, increased taxes are already required to bring in another R43bn over the next three years to fund the state's existing commitments. Current spending must also be cut by R26bn, mostly by reducing the public service (rather than expanding it in the way the NHI requires). Public debt totals more than R2 trillion, the annual interest bill is growing rapidly, and the ratio of public debt to GDP already stands at some 50%.

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In addition, the NHI will do little to address often poor standards in public health care. The problem is not simply high demand, but rather bad management in public hospitals, clinics, and provincial health departments. This helps explain, for example, why the R500m Xhariep District Hospital in Trompsburg (Free State), though completed in 2013, remains as yet unstaffed and unused. In addition, late payments and inefficient administration make for persistent stock-outs of medicines and other consumables, along with the patchy maintenance of essential infrastructure and equipment. These factors, combined with poor hygiene and uncaring staff attitudes, contribute to unnecessary deaths and mounting medical negligence claims – and help explain why only 16% of public hospitals and clinics (or a mere 6%, on the most recent figures available) currently comply sufficiently with basic health care standards to qualify for NHI participation.

The NHI will also put an end to the efficient private health care system on which millions of people (going far beyond the 16% with medical scheme membership) rely. It fails to acknowledge that mounting out-of-pocket payments remain very low as a proportion of overall health spending (at 6.5%). It further fails to recognise that the government's insistence on open enrolment, community rating, and payment 'in full' for 300 PMBs has made medical scheme membership increasingly unaffordable. The government has also barred low-cost medical schemes, without compulsory PMB cover (as proposed in 2015), which could have extended membership to some 15 million more people at an average cost of between R180 and R240 per adult member per month.

The proposed NHI with its flawed assumptions and false promises should be abandoned. Instead the government should allow low-cost medical schemes and low-cost health insurance. It should make it compulsory for all those with formal jobs to take out medical scheme membership, using the new low-cost options where appropriate. It should also require those formally employed to take out low-cost insurance against adverse changes in health status.

All medical schemes should include health savings accounts (HSAs), which would allow people to put some of their monthly medical scheme contributions into a personal 'account' which they own and control. This would give them a choice as to how the monies in their HSAs should be spent. Ideally, individuals should be able to carry forward any unspent monies from one year to the next. When they retire or otherwise stop working, they should be able to access their accumulated HSA monies on a tax-free basis and

use these for any purpose they think fit. This would encourage people to be more prudent in making their health care purchases.

The use of HSAs would encourage doctors and other health care providers to start competing for the custom of people spending what they now regard as their 'own' money. This would stimulate a number of cost-effective innovations, as it has in the United States. There, HSAs have encouraged the introduction of walk-in clinics, telephone and e-mail medical consultations, on-line pharmaceutical purchases with home delivery, and a host of other creative ideas.

In addition, the government should use tax-funded health vouchers to extend similar medical scheme cover and health insurance cover to the unemployed and economically inactive. It should also expand the number of health professionals and health facilities, as there is little point in increasing the demand for health services without also increasing their supply.

Major inefficiencies in the public health care sector must also be overcome. This process can be kick-started by using public-private partnerships to overcome poor management in the public sphere. However, since many of the administrative problems afflicting public health care are the product of damaging employment equity and BEE procurement rules – which benefit a mere 15% of black South Africans while harming the remainder – the government should also shift away from BEE to a new system of 'economic empowerment for the disadvantaged' or 'EED'.

Instead of focusing on (unrealistic) numerical targets, EED would concentrate on overcoming the key barriers to upward mobility. These include anaemic growth, high unemployment, bad schooling, and an increasing culture of dependency and entitlement. EED would focus on all the right '**E**s', for it would aim to bring about rapid **e**conomic growth, **e**xcellent education, very much more **e**mployment, and the promotion of vibrant and successful **e**ntrepreneurship.

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Under this new system, business would earn (voluntary) EED points for direct investments, maintaining and expanding jobs, and contributing to tax revenues and/or export earnings. These are by far the most important contributions to upward mobility that business can make. Jobs and earnings are vital to individual dignity and self-reliance. They also offer people the surest and most sustainable path out of poverty. The tax revenue and/or export earnings that business generates are essential in meeting infrastructure, education, and other needs. Hence, it is only when business of every kind and every size – from the street vendor to the major corporation – is able to thrive and expand that real opportunities can be generated and full employment achieved.

At the same time, the disadvantaged have immediate needs which business can also help to meet. They need quality and affordable health care. They need excellent education. They need proper housing and sound living conditions. At present, the government promises these benefits but often fails adequately to deliver. Some 4% of GDP is spent on public health care, but only 16% (or 6%) of public facilities comply with basic norms and standards. More than 6% of GDP is spent on education, but the schooling system remains one of the worst in the world. Some 3% of GDP goes to housing and community development, but more than 2.1 million households still remain on the national housing waiting list. It will also take at least 20 years, at the state's current rate of delivery, to clear the existing backlog, let alone meet new housing needs.

EED can help address these problems. Instead of making people wait on the state to deliver, individuals should be empowered to meet their own needs via state-funded vouchers for health care, education, and housing. These vouchers would help them buy what they require from private suppliers.

Business can also help improve the health care, education, and housing on offer in various innovative

ways. In the health care context, for example, it could implement the various provider innovations already introduced in the US. In education, it could develop interactive on-line mathematics tutorials to help pupils test their knowledge and understand where their efforts have gone wrong. In the housing sphere, it could develop low-cost housing materials that would be readily available, easy to assemble, and environmentally sound.

With these three vital spheres opened up to private provision and entrepreneurial innovation through the voucher system, the range of improvements introduced could soon be dizzying. Business would earn EED points for all such contributions, while disadvantaged South Africans would benefit enormously.

Business could also contribute financially in various ways. In the health care context, for example, business could help lower paid employees by contributing more than the usual 50% to their medical scheme contributions and health insurance premiums. It could also assist by depositing additional funds into the HSA accounts of low-paid staff. It could top up the tax-funded health vouchers provided by the state to the unemployed and elderly, or make training vouchers available to those wanting to qualify as nurses and other health professionals. An endless array of innovations would be unleashed – all of which would directly help to empower the truly disadvantaged.

*The proposed NHI system is itself a key vehicle for advancing the NDR. It will push the private sector out of a key sphere and could drive much of the skilled middle class out of the country. It doing so, it will further hobble the economy and vastly increase dependency upon the state. It will also turn access to health care into a potent additional political weapon in the hands of the ANC.*

The surest way to increase wealth and health in South Africa is not to nationalise the private health care section under the NHI proposal, but rather to roll back state intervention and allow more economic freedom. Economic freedom – which, in its true sense, means freedom from excessive state control over the economy – is vital to the prosperity of every nation. As data from all over the world has repeatedly shown, it is a crucial factor in achieving higher rates of economic growth, increasing GDP per capita, and extending average life expectancy.

If South Africa is to attain the benefits of economic freedom, the ANC must jettison its commitment to a national democratic revolution (NDR) aimed at ushering in a socialist and then communist future. So long as the ruling party remains wedded to this outdated and damaging ideology, investment will be muted, growth limited, and unemployment high. This dismal situation is also precisely where South Africa now finds itself.

However, even in its current straitened circumstances, the country could still implement a universal health coverage (UHC) system that would be practical, affordable, and effective. However, if such a UHC system is to expand and improve the benefits it offers, South Africa's unemployment rate must fall to 6% or less, its tax base must vastly expand, and its annual growth rate must rise to a minimum of 5% of GDP a year. All these gains can yet be achieved. However, they will become increasingly unattainable if the ANC continues to propel the country down the NDR path.

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Better ways to achieve universal health care must thus be found. Better ways of doing so are outlined here and in *Part 4* of this analysis. South Africans need to understand the great threat that the NHI poses. They also need to mobilise to defeat this threat if they want to avoid losing many of the political and economic freedoms that the ending of apartheid finally brought within their grasp.

# PART 1: BACKGROUND TO THE NHI

**South Africa confronts an exceptionally high burden of disease and a large number of trauma injuries from violent crimes and traffic accidents. It has an extensive and well-funded public health care system, on which it spends 12% of the national budget and 4% of GDP. But the public system often functions poorly because of poor management, over-burdened health professionals, and crippling shortages of medicines and other supplies. Only 16% of the country's roughly 4 000 public hospitals and clinics comply with basic standards of infection control and other norms. Avoidable deaths are increasing, as are medical negligence claims against the state.**

**The country also has an excellent private health care system, with annual spending amounting to some 4.4% of GDP, but relatively few South Africans can afford to access it. A key part of the problem, however, is that government regulations on open enrolment, community rating, mandatory benefits, and solvency ratios have greatly pushed up the costs of medical schemes, making membership increasingly unaffordable. The government has also barred the introduction of low-cost medical schemes and now plans to restrict health insurance, another low-cost option. At the same time, it constantly accuses the private sector of profiteering and extortion. It further claims that the only way to solve the country's health care problems is through the NHI.**

## A heavy burden of disease and injury

South Africa confronts an exceptionally high burden of disease. It has some 7 million people living with HIV/AIDS, amounting to 12.7% of the total population. Of these 7 million, almost 3.5 million are currently on anti-retroviral (ARV) treatment. Under the ARV roll-out achieved thus far, AIDS-related deaths have diminished and average life expectancy has increased to 62 years. However, new HIV infections are still growing rapidly and amounted to close on 530 000 in 2015 alone. This was the highest number of new infections in the world, far exceeding the roughly 197 000 recorded in India (which has a population of some 1.3 billion, compared to South Africa's 55 million). Some R60bn has been budgeted for HIV/AIDS programmes over the next three years, and this amount will have to be greatly increased if ARV treatment is to be rolled out to all those living with HIV.

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HIV infection is continuing to fuel the spread of opportunistic diseases, particularly tuberculosis (TB). The TB prevalence rate rose from 444 per 100 000 people in 1994 to a high of 857 per 100 000 people in 2012, but has since come down to 696 per 100 000 in 2014. According to World Health Organisation (WHO) statistics, roughly 1% of South Africa's 55 million people develop active TB disease each year. World-wide, this is the highest incidence of any country after India and China.

South Africa also confronts a growing burden of non-communicable diseases. Its diabetes prevalence rate has decreased in recent years (to 7.6% in 2015), but its diabetes death rate is one of the highest in the world, standing at 91.7 deaths per 100 000 people in 2014 (as opposed to 57.1 in Botswana, 36.8 in

Ghana, 30.7 in Mozambique, 43.0 in Nigeria, and 39.9 in Uganda, for example). South Africa's hypertension death rate is also far higher (at 44.8 per 100 000 people) than the equivalent rates in Ghana (20.9), Mozambique (15.1), Nigeria (13.8) and Uganda (19.5). Its cancer death rate (106.2 per 100 000 people) also exceeds that in many African states, including Botswana (80.7), Ghana (73.6), and Mozambique (91.8).

In addition, South Africa is ranked fifth worst in the world for the high number of its annual vehicle accidents. Treating the thousands of people injured in this way each year adds significantly to the burden on the health care system. So too do high rates of violent crime. In 2015/16 alone, there were roughly 18 100 attempted murders, close on 52 000 sexual offences (most of them rapes), almost 183 000 serious assaults, and nearly 165 000 common assaults.

The overall cost of treating these injuries is difficult to quantify. In 2010, however, preventable trauma incidents such as stab and gunshot wounds and car-crash injuries cost the KwaZulu-Natal health department some R5bn. More recently in Ceres, a small farming town in the Western Cape with a population of some 33 000, more than 160 people were treated at the local hospital for gunshot and stab wounds in a single month (October 2016). In this small town alone, treatment costs for people injured in this way amount to at least R750 000 a month. They can also easily exceed this if a stabbing victim needs specialist care, for costs then rise from a basic amount of some R4 600 to well over R13 500 per person.

*The number of public sector GPS has gone up from some 7 500 in 2000 to more than 13 600 in 2015, an increase of roughly 80%. The number of public sector specialists has gone up too (from some 3 900 in 2000 to close on 5 000 in 2015).*

Factors of this kind impose an inordinately heavy burden on South Africa's health care system. This burden could be significantly reduced through strong leadership, effective law enforcement, and a greater willingness among South Africans themselves to avoid risky behaviour and criminal conduct. However, little is being done to implement positive changes of this kind.

## Public health care in South Africa

### *Public health resources and budgets*

South Africa has close on 3 200 public clinics, many of them built since 1994. It also has almost 410 public hospitals, providing more than 85 300 beds. There are some 18 600 general practitioners (GPs) and specialists working in the public sector, amounting to 44% of all such health professionals registered in the country. Some 68 000 professional nurses (50% of the total) work in the public sector, as do a similar number of nurses with only a year or two's training. The number of public sector GPS has gone up from some 7 500 in 2000 to more than 13 600 in 2015, an increase of roughly 80%. The number of public sector specialists has gone up too (from some 3 900 in 2000 to close on 5 000 in 2015), but this increase, at 30%, is less marked. The overall people-to-doctor ratio in the public sector, including both GPs and specialists, stood at some 2 950 to 1 in 2015. The people-to-nurse ratio, by contrast, was 411 to 1, a small improvement on the 2000 ratio of 482 to 1.

South Africa allocates around 12% of budgeted government spending to public health care, amounting at present to some 4.1% of GDP. In nominal terms, the health budget has gone up from R15.6bn in 1994/95 to R183bn in 2016/17, an increase of some 1 050%. In real terms it has gone up by an average of 8.5% a year over the last five years or so. However, South Africa gets little bang for its public health care buck.

### *Poor standards in public health care*

Though South Africa has many dedicated health professionals in the public sector, standards of care are often poor. Reasons range from a shortage of doctors and nurses to bad management of public hospitals, persistent shortages of medicines and other consumables, and a widespread failure to comply with basic norms and standards in public hospitals and clinics.

### *An acute shortage of doctors, specialists, and nurses*

Factors pushing health care professionals out of the public system date back to the late 1990s, when the government announced a (supposedly) new focus on primary health care. This was in keeping with the *Declaration of Alma Alta* adopted by the World Health Organisation (WHO) in 1978, which had emphasised the importance of providing easy access to a relatively low level of health care, while also preventing the spread of disease through improved sanitation, access to clean water, and immunisation.

Resources were thus re-allocated from the tertiary sector to the primary one, so as to provide a number of new clinics in under-serviced areas. By 2007 the number of clinics had risen to some 1 600, while head-count visits had increased from some 67 million in 1996/97 to almost 102 million in 2006/07. However, the benefit to the poor was questionable, for a large proportion of the new clinics (60% in 2004) had no properly trained nurses and few had adequate medicines in stock.

At the same time, increased revenue for primary health care came at the expense of the country's top teaching hospitals. The government severely cut the budgets of the best state hospitals, while criticising them for their supposed preoccupation with heart transplants and other 'diseases of the rich'. In many instances, state hospitals (such as Groote Schuur in Cape Town, where the world's first heart transplant had been carried out) were instructed not to carry out such operations any more. This ignored the extent to which Groote Schuur and other tertiary hospitals had long been engaged in helping the poor. It also encouraged an exodus among doctors concerned that the government had little regard, as R W Johnson writes in his book *South Africa's Brave New World*, 'for the things which had made South African medicine so distinguished in the past'. Some health professionals spoke of the need for 'a more careful balancing act' between primary and tertiary health, but Professor Solly Benatar, a scholar of South Africa's health services, was more blunt. Professor Benatar warned that the attrition of tertiary services in favour of primary services which were often dysfunctional meant 'greater losses than gains in health care in the short term and adverse implications for the future'.

> *'Poor leadership and stewardship (taking responsibility) run like a ruinous cancer through the public health care system. Post 1994, many inexperienced managers were placed in positions of seniority and they have struggled to deal with major challenges.'*

President Thabo Mbeki's irrational response to the growing HIV/AIDS pandemic and reluctance to allow the use of ARVs further damaged the public health care sector. It hugely compounded the burden of disease and generated among many doctors in state hospitals a 'feeling of hopelessness, major hopelessness' as to how to cope with these new challenges. It also fuelled a major exodus of doctors and nurses out of the public health care and into private health care or abroad. This added to the pressure on remaining health personnel while demoralising them even further.

### *Poor management*

The government's insistence that job appointments must be based on demographic representivity, rather than skills and experience, is a major but generally unacknowledged factor in what health minister Dr Aaron Motsoaledi has himself described as 'a management crisis' in public hospitals. This has been compounded by the ANC's policy of 'cadre deployment', which regards political loyalty as more important than medical knowledge and makes it difficult to hold managers accountable.

In 2009 a special series of the *Lancet* (a renowned medical journal published in London, New York, and Beijing) focused on South Africa and spelt out in painful detail the negative consequences of poor management in the public health care sector. Wrote the *Lancet* report:

"Poor leadership and stewardship (taking responsibility) run like a ruinous cancer through the public health care system. Post 1994, many inexperienced managers were placed in positions of seniority and they have struggled to deal with major challenges, particularly human resource management. Incompe-

tence within the public sector is widespread and the government has lacked the political will…to manage underperformance in the public sector. Loyalty rather than ability to deliver has been rewarded. Leaders and managers have not been held accountable when mistakes have been made. Without concerted efforts to change national thinking on accountability, South Africa will become a country that is not just a product of its past but one that is continually unable to address the health problems of the present or to prepare for the future."

In 2011 a competency report conducted by the Development Bank of Southern Africa found that 'teachers, nurses, and even clerks whose highest qualification was a matric certificate were running hospitals'. The study was commissioned by Dr Motsoaledi, who 'promised to fix the management crisis in hospitals, including removing under-qualified and poorly performing CEOs and delegating more powers to management to perform elementary but essential functions'. He said unqualified chief executives had been appointed through 'a combination of bad policy and political patronage'. The policy mistake was to think that because public hospitals were now supposed to be run 'on business principles', their chief executives no longer needed a clinical background. This policy had also been abused to allow 'a free-for-all'.

While some hospitals had well-educated chief executives, the minister went on, 'they did not have the right competencies to manage a hospital'. In some of the most extreme cases, people who were previously only at level 8 of the public service – a junior rank where remuneration ranges from R174 000 to R205 000 a year – were appointed to run hospitals. 'In the Northern Cape, most CEOs were nurses, in Limpopo there were a lot of teachers. The criteria provincial departments followed were curious', added Dr Motsoaledi. However, as the minister acknowledged, ridding the system of unqualified managers would not be easy and could certainly not be attempted 'en masse'.

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In September 2012 *The Star* reported on a growing crisis in public health care in Gauteng. The general consensus among a number of health workers, activists, and government officials (who declined to be named) was that 'the crisis was the result of years of poor administrative and financial management, overseen by the provincial department and politicians'. The province's health woes have been building up for well over five years, 'with constant overspending, spending on unfunded mandates, and the awarding of lucrative tenders to government allies who then failed to deliver'. Forensic audits pointing to corruption had generally not been followed up, though R1 billion's worth of tender fraud was now under investigation by the Hawks (a specialist unit within the police, intended to combat corruption and organised crime). The critical challenges facing public health care in Gauteng thus included:

- continual shortages of essential medicines, which was linked to the non-payment of suppliers and poor supply chain management;
- constant shortages of doctors and nurses;
- severely curtailed laboratory services as the province had failed to pay its bills to the National Health Laboratory Service (NHLS), an organisation providing vital diagnostic tests for patients in all nine provinces; and
- a breakdown of critical equipment needed for surgery, cancer, diagnostics, and the treatment of trauma victims, which again was linked to the non-payment of suppliers.

A former minister of science and technology, Mosibudi Mangena, commented that the problems in the public health care system were the result of 'political appointments and incompetence'. Said Mr Mangena: 'Until we insist on the appointment of suitably qualified and competent people to manage health affairs and to hold those we appoint accountable, our hospitals will continue to be death traps.' Ours is a 'murderous

health system', he went on. 'We read, see, and hear, almost daily, about the needless deaths of our people in our hospitals, babies dying in their mothers' wombs, babies being needlessly brain-damaged during childbirth, the lack of linen and food in our facilities, our filthy hospitals.'

Little improvement has been brought about since then. In February 2015, for instance, a number of doctors working in the Free State (who chose to remain anonymous for fear of victimisation) wrote to provincial premier Ace Magashule to describe how the provincial health care system was being destroyed. Not many years ago, the doctors wrote, hospitals in the Free State were 'among the best in the country', providing excellent medical care and training for medical students and specialists. Now many hospitals were in a state of disrepair. Elevators regularly broke down, which meant that hospital staff had to carry patients up and down stairs on stretchers. People in intensive care, who could not be transported in this way, 'simply could not be operated upon, so unnecessary deaths occurred'.

If renovations to hospital buildings were attempted, they were 'often halted midway without any explanation offered'. Moreover, the work that was carried out was 'usually amateurish and sub-standard'. Broken windows were not repaired, but rather covered over with plastic or cardboard. Moreover, while hospitals were neglected, scarce resources were lavished on posh offices for provincial officials.

Worse still, there was 'a constant shortage of the most basic medicines and consumables'. Even the most basic and inexpensive antibiotics were often out of stock. Patients and their families had to provide their own consumables, including wound dressings and basic medicines. Said the doctors: 'Excuses vary from unavailability of stock from the suppliers to ineptitude in the medical depot. Often the suppliers do not deliver stock because they are not being paid by the government.... No one appears to take responsibility and no one is held accountable.' In addition, equipment was often old and outdated. It was seldom serviced and 'almost never replaced when broken'.

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At the same time, doctors who qualified for promotions and pay increases were denied these because of a lack of funds, but were nevertheless expected to take on ever more responsibilities. There were too few ambulances, while 70% of ambulance personnel were inadequately trained and could not provide necessary emergency care. X-ray services were generally not available at night. By contrast, additional and unnecessary management posts were created, even as vacancies for doctors and specialist posts remained unfilled. Commented the doctors: 'Patients lie for weeks and even months awaiting surgery due to lack of equipment or specialists.'

In March 2015 an oversight tour of nine major hospitals by the Democratic Alliance (DA), the official opposition, found 'catastrophic' conditions at most of these institutions. Problems identified by the DA included severe shortages of doctors and other health personnel, 'a chronic shortage' of medicines, an increase in secondary infections within hospitals, a failure to deal properly with medical waste, a shortage of beds, and a failure to maintain generators in working order despite repeated 'load-shedding' or electricity blackouts.

### *Worsening stock-outs of medicines*

In 2012 an audit of public health care facilities found that average compliance scores were 54% on the availability of medicines and supplies. A one-time head of a trauma unit said that government hospitals often ran out of such essentials as pain-killing drugs. 'One day we run out of Panado, so we have to use morphine even on small babies. The next day there will be no morphine, so we have to use Panado.' In

2013 a group of non-governmental organisations in the health field reported that 20% of more than 2 000 facilities surveyed ran out of ARVs and TB medication.

Since then, complaints about medicine stock-outs have increased rather than declined. In May 2015 *The Times* reported that 'the current list of medicines that are out of stock or in short supply around the country runs to six pages'. It includes antibiotics, TB medicines, ARVs for adults and children, and drugs to treat high blood pressure, anxiety, epilepsy, fungal infections, and pain. A civil society organisation, the Stop Stock-outs Project, added that shortages were assuming 'crisis proportions'. The deficits were also increasing the risk of drug resistance developing among patients, which could make it even more difficult to counter the massive HIV/AIDS pandemic. In addition, as one Gauteng doctor noted, a 'severe' shortage of first-line antibiotics meant that 'much more potent and expensive ones had to be used to treat simple infections'. This was 'bad practice and could lead to antibiotic resistance, but clinicians had no choice'.

Dr Motsoaledi blamed the deficits on a global shortage of the active ingredients needed for various medicines, while a national survey by Stop Stock-outs found that manufacturers had difficulty in supplying in roughly 20% of cases. But the survey also showed that 80% of the shortages were due to logistical problems. Reported *Business Day*: '[Stop Stock-outs] said that 80% of reported cases were due to challenges between medicine depots and clinics at provincial and district levels, such as incorrect quantities of drugs ordered, inaccurate forecasting, and poor stock management'. Often, as the *Mail & Guardian* added, 'the medicine was in fact available at the storage depot – but the drugs could not be traced because there was no proper record-keeping system'.

### *Treatment delays*

Delays in treatment have long been common, and again the situation remains unresolved. In 2015, for instance, at the Chris Hani Baragwanath Hospital in Soweto, thousands of patients were on long waiting lists for various surgical procedures. In March 2015, a 56-year-old man, Aubrey Moreane, who urgently needed hip replacement surgery, was told he would have to wait seven years for this. Overall, there were close on 5 000 patients waiting for operations, of whom more than half needed cataract procedures. In June 2015, however, Gauteng health MEC Qedani Mahlangu acknowledged that the cataract backlog was even worse than previously admitted, with more than 6 000 patients waiting for cataract surgery. Many of these individuals had been waiting for up to three years.

*In June 2015 a study carried out by the School of Public Health at the University of the Witwatersrand reported that the health care system was 'sick with corruption and haemorrhaging money in irregular spending'. It found that R24 billion of provincial health department expenditure between 2009 and 2013 was 'irregular' though not necessarily corrupt.*

### *Financial mismanagement*

In June 2015 a study carried out by the School of Public Health at the University of the Witwatersrand reported that the health care system was 'sick with corruption and haemorrhaging money in irregular spending'. The study, carried out by Professor Laeticia Rispel and two of her colleagues, was based on reports by the auditor general over nine years, interviews with leaders in health care, and an analysis of media reports. It found that R24 billion of provincial health department expenditure between 2009 and 2013 was 'irregular' (not in keeping with procurement procedures), though not necessarily corrupt. The number of provincial health departments receiving unqualified audits had also decreased, from seven in 2004/05 to three in 2012/13.

Many health department employees said they felt 'disempowered' and unable to act against corruption and irregular spending, while a trade unionist told the researchers: 'If you are a strong manager, you get targeted and destroyed. If you want to keep your job, you become corrupt yourself.' The chief executive of

a state hospital added: 'Attitudes are appalling. People know that they can get away with it.' The national health department said it was 'concerned about corruption and encouraged people to report it regardless of who the perpetrator was'. However, the researchers cautioned that much stronger leadership and a good deal of 'political will' would be needed to target it effectively.

Persistent failures to pay suppliers have also contributed to shortages of medicines, medical equipment, and other supplies. In addition, vacant posts often cannot be filled because a provincial department has overspent in previous years and now has to cut costs. This, in turn, has contributed to a loss of nursing staff, who find themselves so overburdened that they prefer to resign.

By January 2015 the National Health Laboratory Service (NHLS) was reportedly in a critical condition because provincial administrations had failed to pay it the billions of rand they owed. The NHLS is a vital institution, for it responsible for most HIV and TB tests in the public health system and plays a critical role in screening for cancer. Moreover, without diagnostic tests, doctors are in the dark in treating many patients and cannot prescribe the drugs required.

An article in the *Mail & Guardian* quantified the amount owing to the NHLS at R5bn. It also reported that the NHLS was 'leaking skilled staff' who were demoralised by the situation and uncertain as to whether their salaries would be paid. Many of those leaving were skilled pathologists with many years of experience, who were now being replaced by 'people fresh out of college'. The situation has since improved, but unpaid debts over the past two years still exceed R3bn. The NHLS says it is 'constantly engaging with the provinces to follow up on their outstanding debts'. However, Dr Motsoaledi blames the payment shortfalls on the NHLS itself, which he accuses of having a 'chaotic, glitch-riddled billing system'.

### *Avoidable deaths*

As standards of public health care have declined, so avoidable deaths have risen. In May 2015 a report compiled by the South African Medical Research Council (a research organisation founded in 1969) found that more than 80 000 babies had died at some 590 public facilities over a two-year period. Though the great majority of the deaths were stillbirths, more than 24 500 early neonatal deaths had also been recorded. Many of these deaths, said the report, could have been avoided if health care workers had followed simple guidelines, such as monitoring the heart rate of the foetus and looking after the overall health of the mother.

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South Africa's maternal mortality rate, by the standard metric of deaths per 100 000 live births, went up from an estimated 150 in 1998 to 369 in 2001 and increased further to 625 in 2007. More recent figures put the rate at 140 deaths per 100 000 live births, which shows the positive impact that effective ARV treatment for HIV/AIDS has had. However, South Africa's maternal mortality rate (140) is still very high compared to those in countries with similar per capita income levels: 68 in Peru, 64 in Colombia, and 27 in China.

A key cause of maternal deaths is bleeding before or after labour. About 16% of mothers who die before or shortly after birth die from blood loss. About a third of these women die from bleeding out during or after Caesarean sections. In about 70% of cases, the deaths of women during or after C-sections could have been prevented, according to a recent review of maternal death audits published in the *South African Medical Journal*. The underlying reasons are a dearth of surgical skills in rural hospitals, a lack of emergency blood supplies, and delays in calling for help.

### *Mounting cases of medical negligence*

In many instances, babies have survived poor care at birth but have been left badly brain damaged. An increasing number of medical negligence cases – many of them involving children harmed in this way – have

thus been brought before the courts in recent years. In one case, the Pretoria High Court awarded R23m in compensation to four-year-old Ntsako Mathebula, who was left with cerebral palsy, mental retardation, epilepsy, and other severe medical and developmental problems when medical staff at Tembisa Hospital on the east Rand failed to perform an emergency caesarean on his mother in November 2010.

In another case, the North West MEC of health was ordered to pay more than R5.6m in damages to compensate a 12-year-old boy for negligence during his birth. In yet another instance, the Gauteng health MEC was ordered to pay more than R8.3m as compensation for Carlisle Buys, who was left a cerebral quadriplegic through the negligence of staff at a district hospital in Pretoria.

Another botched birth resulted in 2015 in the awarding of R5m in damages against the Gauteng MEC for health. In this instance, Kamogelo Kau suffered a low blood sugar induced brain injury when his mother Christinah gave birth to him at the Pholosong Hospital in Tsakane (Brakpan) in 2006. His brain injury was aggravated by a lack of oxygen after his birth and by poorly treated convulsions, which left him with severe cerebral palsy. Reported *The Citizen*: 'The boy's movements are impaired. He suffers from spasticity and quadriparesis and cannot walk, run, or sit for long periods. His speech has been severely affected, he is incontinent, and he moves by performing a kind of "bunny hop". An occupational therapist described the loss he had suffered as devastating not only for him but also his mother and family as he would never be able to live independently.'

*In one case, the Pretoria High Court awarded R23m to four-year-old Ntsako Mathebula, who was left with cerebral palsy, mental retardation, epilepsy, and other severe medical problems when medical staff at Tembisa Hospital failed to perform an emergency caesarean on his mother.*

Significant damages awards have also been made in various other cases which came before the courts in 2015. The Limpopo health MEC, for instance, was ordered to pay R1.25m in damages to a Thabazimbi businessman who lost his leg and his business because of shoddy treatment at a state hospital in the town. The Gauteng health MEC was ordered to pay R450 000 in compensation to a Witbank receptionist whose husband died after a gastric tube was inserted into his lung instead of his stomach. The Johannesburg High Court awarded Brenda Mavimbela R13m in damages for the mistreatment of her 18-month old daughter, Nonjabulo, at the Far East Rand Hospital. The toddler was treated for bacterial meningitis when in fact she had tuberculous meningitis. As a result, she became permanently disabled. She is blind and cannot talk, walk, or feed herself.

By March 2015, the value of medical negligence claims lodged against the Gauteng department had skyrocketed from R6.6bn to R10.1bn, while the government's overall contingent liability for medical malpractice lawsuits amounted to R25bn – a sum which has since risen to R35bn. Dr Motsoaledi has blamed personal injury lawyers for the increase, saying they are 'creating a national crisis' through their 'unprofessional conduct' and excessive charges'. However, as *Business Day* responded in an editorial: 'If the courts are awarding large amounts in damages, it is surely because malpractice is being proved.' Curing this should be the minister's focus, rather than trying to prove that lawyers are conspiring to milk the public health care system.

### *'Appalling' outcomes on audits of health standards*

In 2012 the Department of Health released the results of a 'baseline' audit of health standards at some 3900 public hospitals, clinics and other health facilities. The report found that average compliance scores (on six ministerial priority areas) were 30% on 'positive and caring attitudes', 34% on 'improving patient safety and security', 50% on 'infection prevention and control', 50% on 'cleanliness', 54% on the 'availability of medicines and supplies', and 68% on waiting times. Average scores on compliance in five functional

areas were still worse: 53% on 'patient care', 45% on 'support services', 40% on 'infrastructure', 43% on 'management' and 38% on 'clinical services'.

Some compliance scores were even worse. The availability of essential drugs in clinics was a 77% 'failure', while the score for vital health technology in maternity wards and operating theatres was a 93% 'failure' in both instances. Only two facilities could guarantee patient safety. All of this, the audit stated, was despite the fact that public sector health funding had increased by an average of 8.5% a year in real terms over the past five years.

Dr Motsoaledi described the audit outcomes as 'appalling'. In response, he announced the introduction of a new Office of Health Standards Compliance, which would in future 'visit hospitals unannounced' to assess issues such as cleanliness, staff attitudes, infection controls and the availability of medicines. However, as journalist Moshoeshoe Monare wrote in *The Sunday Independent*, the OHSC would essentially be doing what 'the provincial departments of health, hospital CEOs, and nursing matrons were supposed to be attending to'. If staff were failing to fulfil their functions, then immediate disciplinary action was required, not a lengthy investigative process by yet another bureaucracy.

> *The OHSC managed to re-inspect 417 state facilities in 2014/15. Only 3% of these facilities were found to be 'compliant'. Another 13% were found to conditionally compliant. The remaining 84% were non-compliant, of which 39.8% were 'critically non-compliant'.*

The OHSC was nevertheless established in 2013 and managed to re-inspect 417 state facilities in the 2014/15 financial year. The results were dismal, for only 3% of these facilities were found to be 'compliant'. Another 13% were compliant 'with requirements' or were 'conditionally compliant'. The remaining 84% were non-compliant, of which 16.5% were 'conditionally compliant with serious concerns', 27.8% were 'non-compliant' and 39.8% were 'critically non-compliant'.

## Private health care in South Africa

In 2009 South Africa's private health care system was rated seventh-best in the world, whereas an international poll of public hospitals that same year saw the country's public health sector as 'languishing among the bottom three in the world'. However, in the face of persistently high unemployment, compounded by poor schooling and limited skills, relatively few South Africans are able to afford the costs of private health care.

The country has roughly 200 private hospitals, offering access to some 31 000 beds. Some 56% of doctors and specialists work in the private sector, as do some 50% of professional nurses. In 2016/17, spending on private health care is expected to amount to R189bn, of which close on 85% (R158bn) will go to medical schemes, R24bn will be spent on out-of-pocket expenses, and R4.6bn will go to medical insurance.

Instead of acknowledging the country's high jobless rate and how this limits access to private treatment, Dr Motsoaledi has repeatedly accused the private sector of charging extortionate prices because of its callous willingness to put 'profits before people'. This accusation has little factual foundation. Moreover, it is often the government's own regulations which have pushed up the costs of medical scheme membership and made private health care increasingly unaffordable for many South Africans.

### *Regulations affecting medical scheme membership*

The number of people belonging to medical schemes has risen from 6.9 million in 1997 to 8.8m in 2015. However, because the South African population has also increased over this period, medical scheme membership, as a proportion of total population, has remained much the same at roughly 16%. The demographic representation of medical schemes members has nevertheless changed substantially over the years, for

50% of members are now black, while 10% are coloured or Indian and only the remaining 40% are white.

Often, moreover, it is the government's own regulations that have pushed up the costs of medical scheme membership. Relevant here, for instance, is a regulation requiring medical schemes to maintain their reserves at 25% of gross annual contributions received. There is no scientific or actuarial foundation for this solvency ratio, which seems to have been arbitrarily chosen. In 2015 most schemes had solvency ratios above the set level, with the average ratio standing at 32.6%. (The exception was the Government Employees' Medical Scheme (GEMS), the second largest medical scheme in the country, which had a solvency ratio of less than 10%. The government has long turned a blind eye to this shortcoming.)

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

Also important is the Competition Act of 1998, which bars price fixing and collusion. In 2004 the Competition Commission used these provisions to prohibit collective bargaining between medical schemes and health practitioners on the fees to be charged for medical services. Medical schemes have responded by setting their own caps on how much they will pay for consultations and procedures. However, many doctors and specialists charge more than these capped amounts, which means that members have to cover the shortfall themselves via co-payments. According to Humphrey Zokufa, chief executive of the Board of Healthcare Funders (BHF), an organisation which represents some 65% of medical schemes, these out-of-pocket payments are a source of much unhappiness among members and are prompting a further exodus from medical schemes.

### *Open enrolment and community rating*

Particularly important are regulations requiring 'open' enrolment and 'community' (or non risk-rated) premiums. Under these regulations, no prospective member may be turned away, irrespective of age or illness, or made to pay a higher premium (though limited 'late-joiner' penalties and waiting periods for existing conditions are allowed). This means that medical schemes must not only accept high-risk individuals, but must also charge them the same premiums as they charge low-risk people. The upshot is that the young and healthy have little reason to join medical schemes, while the risk pool of insured people becomes progressively smaller and less healthy. This in turn drives up contribution levels and makes membership of medical schemes increasingly unaffordable.

*Particularly important are regulations requiring 'open' enrolment and 'community' (or non risk-rated) premiums. Under these regulations, the young and healthy have little reason to join medical schemes, while the risk pool of insured people becomes progressively older and less healthy.*

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

### *Full payment for some 300 prescribed minimum benefits (PMBs)*

Even more important are rules (in section 29 of the Medical Schemes Act and its accompanying regulation 8) requiring all medical schemes to provide all their members with 'prescribed minimum benefits' (PMBs)

for a host of specified conditions. Included on the PMB list are 270 medical conditions, such as cancer and pneumonia, along with 25 chronic conditions plus access to emergency care. Under Regulation 8, moreover, medical schemes must 'pay in full' for the treatment of PMB conditions. All medical scheme members, irrespective of what cover they have signed on to receive, are entitled to these PMBs. This in turn means that medical schemes cannot offer membership at less than R605 per person per month, which is the minimum amount needed to cover the costs of these PMBs. Again, this pushes up medical scheme premiums for everyone.

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

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

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

> *'Medical schemes found themselves responsible for all costs – no matter how high – related to the treatment of PMB conditions. This open-ended liability caused havoc on their balance sheets.'*

In July 2015 Dr Motsoaledi tabled a draft amendment to Regulation 8, under which medical schemes would be able to limit their PMB payments to doctors and specialists to the fees set out in a 2006 tariff guide, called the National Health Reference Price List. The 2006 figures would be adjusted by the consumer price inflation rate, he said, but would still be well below what many doctors and other service providers were charging for PMBs. But a number of doctors responded that the proposal was unfair, as the 2006 reference list took no account of the actual costs of running a practice or providing a service. In addition, medical inflation had far exceeded consumer inflation since 2006, making the maximum permitted fees all the more inadequate. In the face of these objections, the minister opted to leave the matter unresolved. The regulatory requirement that all medical schemes must 'pay in full' for PMBs thus continues to price medical aid coverage beyond the reach of most households.

### *Low-cost medical schemes still barred*

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

Costs would be kept down by exempting these schemes from having to cover all PMBs, while members would be required to use state hospitals rather than private ones. At the same time, the schemes would provide a mandatory minimum package of services, including five consultations a year with a private

general practitioner (GP), access to pre- and post-natal programmes, routine health screenings, and the provision of chronic and acute medicines. This in itself would reduce the burden on the state and spare millions of people from having to spend hours or days waiting for such services at public facilities. (To prevent existing medical scheme members from 'buying down', the low-cost options would be available solely to people earning below the personal income tax threshold, then roughly R6 000 a month for people below the age of 65.)

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

### *Other regulations that push up private health care costs*

Another low-cost option, which is already in operation, is now under threat from the state. Hundreds of thousands of low-income individuals have responded to the growing cost of medical scheme membership by taking out health insurance covering them for the costs of hospitalisation and providing them with primary health care benefits. These combination insurance products are not subject to medical scheme rules, which means they can differentiate on the basis of age and health. Insurance products are thus particularly attractive to younger and healthier people – the very market that medical schemes need to cross-subsidise their older and sicker members.

> *'Two industry sources mentioned that the council received a call from the Department of Health telling it to withdraw the low-cost benefit options immediately as they were considered a stumbling block on the path to the NHI.' Dr Motsoaledi denied this.*

The Department of Health, acting together with the National Treasury, now plans to ban insurers from offering primary health care coverage, saying these policies involve the business of a medical scheme and must be registered and regulated as such. This prohibition will take effect in 2018 (while the two-year period between now and then will ostensibly be used to devise a low-cost medical scheme). Also from 2018, existing hospital cash plans will be restricted to providing benefits capped at R3 000 a day or a lump sum of R20 000 a year. Current 'gap-cover' insurance policies, which fund shortfalls between what doctors charge for hospital procedures and what medical schemes pay, will be restricted to providing benefits of R150 000 a year.

Health insurers will also be barred from applying risk rating and charging individuals premiums based on their individual health status. 'Top-up' insurance cover, which pays out when people have exhausted their annual medical scheme benefits, will be prohibited too. These restrictions will significantly harm the roughly 800 000 South Africans who currently rely on insurance cover of this kind because they cannot afford costly medical scheme membership.

In addition, though a shortage of doctors and specialists further contributes to high costs, the government persists in refusing to allow private institutions to train doctors. Instead, the burden of training new doctors continues to rest solely on the country's public universities, which for many years have had the

capacity to train only some 1 300 new doctors a year: a total first reached in the 1970s. Though the number being trained at these institutions is now being pushed up to some 1 900, this increase is too limited to meet the needs of an expanding population with a growing burden of disease.

The training of nurses has also been curtailed by the government's decision in the mid 1990s to close down a number of nursing colleges. Though the state has since pledged to reopen these, little progress has thus far been made. The private sector has sought to fill the gap by training some two thirds of the nurses now qualifying in South Africa. However, the state remains reluctant to allow the private sector to train more. This has contributed to a critical shortage of nurses, especially in specialist areas such as intensive care.

Also relevant are the government's restrictions on the building of new private hospitals and clinics, as this constrains new entrants and reduces competition. Significant too is the state's prohibition on private hospitals employing doctors and specialists, which means that these medical practitioners must fund their own consulting rooms and equipment and bill their patients themselves. By contrast, there would be savings if hospitals could employ them, provide them with necessary facilities, and benefit from the resulting economies of scale.

### *The government's accusations against the private health care sector*

The ruling ANC is ideologically hostile to business and has long demonstrated a deep suspicion of the 'profit' motive in private health care. Dr Motsoaledi has also repeatedly accused the private system of profiteering and extortion (see *Part 4*).

*The ruling ANC is ideologically hostile to business and has long demonstrated a deep suspicion of the 'profit' motive in private health care. Dr Motsoaledi has also repeatedly accused the private system of profiteering and extortion. In 2011, for instance, he lashed out at the private health care sector, blaming it for the country's poor health care outcomes.*

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

According to Mr Zietsman, the minister had failed to mention the huge state subsidy, paid by taxpayers, that financed public health. He had also failed to acknowledge that there could be differences in the conditions involved: most circumcisions were straightforward, but some were not. Spinal decompression could be done in different ways, depending on particular needs, and some were more complex than others. On a more appropriate comparison, added Mr Zietsman, private hospital costs were on average only 1.4 times more expensive than public hospital costs. If all relevant factors were taken into account and like was more strictly equated with like, then private hospital costs were a mere 1.1 times those of public hospitals.

At the urging of Dr Motsoaledi, the Competition Commission is currently investigating high prices in private health care and the reasons for them. Its Health Market Inquiry, which has this year been holding oral hearings into private health care costs, is now expected to be finalised only in 2017. Pressure from the health minister for such an inquiry goes back to 2010 when Dr Motsoaledi said he wanted an independent commission, not simply to investigate costs, but rather to 'regulate prices in the private healthcare sector'.

In documents submitted to the Health Market Inquiry, the three main hospital groups, along with other commentators, have disputed the health minister's accusations. The main cost drivers in private hospitals, they say, lie not in private sector greed but rather in increased utilisation, a growing burden of disease, an ageing population, the introduction of new medicines and medical technologies, increased labour costs,

especially for nurses (as the private sector has had to push up salaries to compete with rapid wage increases in the public service), steep increases in electricity and other administered prices, the declining value of the rand, and significant increases in the overall consumer price index which add to food and other input costs.

Dr Motsoaledi continues to reject this perspective, instead stating that the mere 'existence of medical schemes is a punishment for poor people'. The minister has also put great emphasis on a recent study comparing private hospital prices in South Africa with hospital prices in 20 countries belonging to the Organisation for Economic Co-operation and Development (OECD). These countries include the United Kingdom, Germany, Switzerland, Luxembourg, and the Nordic states, along with several eastern European nations. The study, which was drawn up by the OECD and the South African country office of the World Health Organisation (WHO), concludes that South Africa's hospital services are significantly less affordable than those on offer in these wealthy OECD countries.

*The minister has also put great emphasis on a recent study comparing private hospital prices in South Africa with hospital prices in 20 OECD countries. However, the OECD/WHO study is fundamentally flawed in two key ways.*

However, the OECD/WHO study is fundamentally flawed in two key ways. First, it contrasts private hospitals in South Africa with a range of both public and private hospitals in OECD countries, thus undermining the validity of its price comparisons. Secondly, it contrasts hospital price levels with average GDP per capita in the comparator countries. But this overlooks the fact that average GDP per person in South Africa is greatly reduced by the country's youthful population (more than half South Africans are under the age of 25) and also by its high unemployment rate. This now stands at 27% in general and at an even more disturbing 54% among the country's youth. Average GDP per capita is naturally much higher in the 20 OECD states, which have very different demographic and unemployment profiles.

## The NHI the supposed solution

Against this background, the ANC has for many years been determined to introduce its proposed NHI system in South Africa. This, it says, will relieve the unfair burden on the public health care sector, remove inherent injustices in the current health system, and give all South Africans equal access to quality and affordable health services. This vision is a beguiling one. However, it is unlikely to be achieved in practice, as explained in *Parts 2* and *3*.

# PART 2: PROBLEMS WITH THE NHI PROPOSAL

**The White Paper proposes a 'single payer' system, in which all health monies will be pooled within a single fund from which all health expenses will be paid. The NHI will introduce price controls on all health services, medicines, and other health products. It will also control every aspect of medical care, from the treatment protocols to be followed to the medicines to be used and the health technologies to be permitted. These changes will supposedly give 55 million South Africans universal access to quality, affordable health services that are free at the point of delivery.**

**However, the rationale for the NHI, as set out in the White Paper, is flawed and unconvincing. The White Paper is also vague on the benefits to be provided, the size of the bureaucracy required, and the number of health facilities likely to qualify to take part in the NHI. It brushes over the fact that almost all medical schemes will be forced out of business and that the private health care system will effectively be ended. It also overlooks the risk that many health practitioners could decide to emigrate, reducing the supply of health services just as the NHI increases the demand for them.**

## A single-payer system of universal health coverage

According to the White Paper, 'National Health Insurance (NHI) is a health financing system that is designed to pool funds to provide universal access to quality, affordable health services for all South Africans, based on their health needs and irrespective of their socio-economic status'. The NHI system will be implemented through 'the creation of a single fund that is publicly financed and publicly administered', while 'the health services covered by NHI will be provided free at the point of care'.

This description emphasises the many benefits the NHI system is supposed to usher in. In practice, however, the NHI will reduce access to health care, rather than expand it. It will also give the state control over all aspects of medical treatment, effectively put an end to the country's excellent private health care system. It will also encourage the emigration of people with scarce skills, and make it for more difficult for all South Africans to obtain the health services they require.

> *The White Paper's stated rationale for the introduction of the NHI system is flawed and unconvincing, resting on dubious assumptions rather than accurate analysis. These failings make for a skewed diagnosis of current health care problems, helping to generate a skewed prescription as to how these challenges can best be overcome.*

The White Paper's stated rationale for the introduction of the NHI system is also flawed and unconvincing, resting on dubious assumptions rather than accurate analysis. These failings make for a skewed diagnosis of current health care problems, helping to generate a skewed prescription as to how these challenges can best be overcome.

## Stated reasons for the NHI proposal

### *The World Health Organisation requires it*

According to the White Paper, the World Health Organisation (WHO) is 'encouraging' countries to move

towards 'universal health coverage'. Such coverage, in the words of the WHO, is intended to ensure that 'all people can use' the health services they need. In addition, these services should be 'of sufficient quality to be effective' and should 'not expose their users to financial hardship'.

The WHO's recommendations are thus more tentative than health minister Dr Aaron Motsoaledi is willing to allow. According to the minister, South Africa has no choice but to introduce the NHI because the WHO insists on member countries having universal health coverage of this kind. This exaggerates what the WHO has said. (It also, of course, ignores South Africa's willingness to overlook its binding treaty obligations on corruption and the International Criminal Court, among other things.) In addition, the minister's stance obscures the fact that relatively few nations have introduced universal health coverage (the White Paper cites ten) – and that these countries have much greater wealth and bigger tax bases on which to draw.

Moreover, the WHO does not in fact prescribe how universal health coverage is to be achieved. It recommends that countries should find ways to 'pool funds,…so as to spread the financial risks of illness across the population' and avoid crippling health care costs for both the poor and the rich. But it also stresses that nations must choose the systems that suit them best – and that whatever option is adopted must be affordable in the long term. The WHO further categorically states that 'universal health care does not mean free coverage for all possible health interventions, regardless of the cost, as no country can provide all services free of charge on a sustainable basis'.

*The White Paper thus implies that the very existence of a private health care system, separate from the state one, is the predominant reason for inadequate health services in South Africa. It further suggests that poor performance in the public service is primarily the fault of the private sector.*

### *A two-tier health system*

The White Paper repeatedly derides the health care system in South Africa as 'a two-tiered system divided along socio-economic lines'. It identifies this as the primary reason for 'inequity' in health care provision, saying: 'The main contributor to inequity in health care is the existence of a two-tier healthcare system, where the rich pool their health care funds and resources separately from the poor.' According to the White Paper, the two-tier system has also resulted 'in a mal-distribution of key health professionals between the public and private health sectors'. This is because 'scarce health professionals naturally migrate towards the private health care system which is better resourced financially relative to the population it serves'.

The White Paper thus implies that the very existence of a private health care system, separate from the state one, is the predominant reason for inadequate health services in South Africa. It further suggests that poor performance in the public service is primarily the fault of the private sector. However, the main problem with the public health care sector is that the considerable resources available to it are poorly managed and often wasted, as described in *Part 1*. By contrast, the efficient private health care system is hugely beneficial to all who use it. Hence, the key challenge is not to put an end to private health care, but rather to give all South Africans increased access to its benefits.

### *An alleged 'mal-distribution' of health care professionals*

The White Paper further assumes that the private health care system poaches health care professionals from the public system, so resulting in a 'mal-distribution' of resources between the two. However, this 'mal-distribution' is less acute than the White Paper suggests.

In 2015, 44% of general practitioners (GPs) and specialists worked in the public sector, which is close on half the total number. Among professional nurses, more than half (51.2%) worked in the public sector, while the situation was similar for nursing assistants (49.5%) and enrolled nurses (46.5%).

Among specialists, 42% currently work in the public service, while 59% practise privately. However, among family physicians, forensic pathologists, and those in public health medicine, there are in fact more specialists in the public service than there are in private practice. In addition, specialists engaged in emer-

gency medicine are equally split between the public and private spheres, as are paediatricians, physicians, surgeons, and radiation oncologists.

Contrary to what the White Paper suggests, it is not the 'fault' of the private sector that more specialists choose to work there than in the public service. Rather, it is the government's own policies and actions that have contributed to this outcome. The government's increasing focus on primary health care has resulted in a major shift in funding away from public hospitals. This has left many specialists with little choice but to turn to private practice (or leave the country). Persistent mismanagement in the public sector has also helped to drive out specialists and other health care professionals, as has the government's flawed handling of the HIV/AIDS crisis.

In addition, the public service has for some years put its focus on hiring administrative staff, rather than medical personnel. As a result, the number of 'core administrative' staff employed in the public sector went up from some 33 330 in 2012 to roughly 37 330 in 2015, an increase of some 12%. At the same time, the number of doctors shrank slightly (from 19 422 to 19 352). The upshot is that doctors are now outnumbered by administrative staff by a ratio of some two to one.

### *The supposed '84:16' dichotomy*

According to the White Paper, 'South Africa spends 8.5% of GDP on health. Of this, 4.1% of GDP is spent on 84% of the population, the majority utilising the public health sector, whilst 4.4 % of GDP is spent on only 16% of the population in 2015/16'.

The White Paper simplistically assumes that, because 16% of the population belongs to a medical aid scheme, the remaining 84% of the population must depend on the public health care system. In fact, however, many people who do not belong to medical aids also use the private system, preferring to make out-of-pocket payments for private treatment than rely on failing public health facilities with long waiting times and often poor standards of treatment.

> *The proportion of people treated privately varies between 28% and 38% in general. Some 37% of people use private GPs, while 38% rely on private nurses, 29% go to private hospitals, and 59% use private specialists.*

The proportion of people treated in the private sector thus varies between 28% and 38% in general, leaving between 72% and 62% to seek treatment from the state. More detailed figures on public/private utilisation in 2015 show that 37% of people use private GPs, while 38% rely on private nurses, 29% go to private hospitals, and 59% use private specialists.

The White Paper also suggests that the private sector is 'not doing its share' in meeting the country's health needs. But the private sector in fact pays the great bulk of all health care costs in South Africa. The roughly R189bn to be spent on private health care in 2016/17 comes mostly from private firms and individuals and their contributions to medical schemes, medical insurance, and out-of-pocket fees. The roughly R183bn budgeted for public health care expenditure in 2016/17 comes from tax revenues, the bulk of which are contributed by private firms and individuals. In addition, the tax system is extremely progressive, for the wealthiest quintile contributes some 82% of total health care financing but receives only 36% of the benefits.

### *Out-of-pocket payments are too high*

The White Paper criticises the 'out-of-pocket' payments that millions of South Africans are often obliged to make when they seek health care services from either the public or the private sectors.

In the public sector, primary health care is free of charge. At higher levels of care, children under six years of age, along with pregnant women, the disabled, and the indigent are exempt from paying user fees.

People who use public hospitals and earn above a specified level (roughly R6 250 a month) are supposed to pay limited fees. Though the payment obligation is often not enforced, the amount thus generated averages some R450 million a year.

In the private sector, people who do not belong to medical schemes but nevertheless prefer to seek private health treatment pay the necessary fees out of their own pockets. So too do medical aid members who have exhausted their annual benefits. In addition, those belonging to medical schemes are often obliged to make co-payments for medical fees that exceed the tariff applied by their schemes. The White Paper condemns these out-of-pocket payments, which are expected to amount to R24bn in 2016/17, saying they are used to deter people from seeking treatment. They also 'entrench inequalities' by making it difficult for the poor to afford medical treatment.

However, international comparison shows that co-payments in South Africa make up an unusually small proportion of total health expenditure in the country. According to the *World Development Indicators 2016* compiled by the World Bank, out-of-pocket payments in South Africa make up 6.5% of total health expenditure, whereas the equivalent proportions in the BRIC countries are 25.5% in Brazil, 45.8% in Russia, 62.4% in India, and 32.0% in China.

The South African proportion, at 6.5%, is also far lower than that in many other emerging countries, including Egypt (55.7%), Indonesia (46.9%), Mauritius (46.4%), Mexico (44.0%), Pakistan (56.3%), the Philippines (53.7%) and Sri Lanka (42.1%). It is also much lower than equivalent proportions in other African countries, including Angola (24.0%), Cote d'Ivoire (50.8%), Ghana (26.8%), Kenya (26.1%), Nigeria (71.7%), and Tanzania (23.2%).

*Out-of-pocket payments in South Africa make up 6.5% of total health expenditure, whereas the equivalent proportions in the BRIC countries are 25.5% in Brazil, 45.8% in Russia, 62.4% in India, and 32.0% in China.*

The White Paper implies that out-of-pocket payments are as burdensome in South Africa as elsewhere, but this is not in fact the case. It is nevertheless important to find ways of helping people to fund such payments. Without such assistance, out-of-pocket payments could, of course, have catastrophic financial consequences for households in instances of severe illness or injury. However, this goal can be achieved without introducing the NHI system, as described in *Part 4*.

### *Private health care costs are inordinately high*

The White Paper further assumes that private health-care costs are inordinately high – and that the NHI system offers the only way to reduce them. Noting that 'medical scheme members are not well protected from the escalating costs of health care', it states that the private sector is characterised by:

(a) 'exorbitant costs due largely to a fee-for-service model';

(b) an 'imbalance in tariff negotiations between purchasers and providers'; and

(c) 'small and fragmented risk pools in each medical scheme, where there is limited cross subsidy between the young and old, the sick and healthy,…the rich and the poor'.

The White Paper adds that, for the past ten years, medical schemes have been 'increasing member contributions at levels that are higher than CPI [the consumer price index], whilst the health benefits of members have been reducing significantly'. Private hospitals, it adds, are thus 'least affordable when compared to OECD countries, even for individuals at higher levels of income'.

However, as set out in *Part 1*, it is often the government's own regulations (on open enrolment, community rating, compulsory cover for PMBs, and high solvency ratios) that have pushed up the costs of medical schemes. This is primarily what has compelled them to increase contributions even as they have limited the

benefits they cover. The OECD research cited is also methodologically flawed, as earlier described. It is, of course, correct that medical inflation rates exceed annual CPI rates, but prices for health care in South Africa have in fact been rising more slowly than those in other countries. Between 2009 and 2012, for instance, they went up by 4%, whereas the global average over this period was 6.2%. In 2011, moreover, South Africa came 8th best out of 52 countries surveyed on the magnitude of its health care cost inflation.

### *Health care should not be 'commodified'*

The health minister, along with the ANC's allies in the South African Communist Party (SACP) and the Congress of South African Trade Unions (Cosatu), have repeatedly stressed that the government must be the key provider of health care in the country. This, they claim, is because health care is 'a public good and not just any commodity'. This perspective is also reflected in the White Paper, which stresses that health care 'must not be treated as a commodity, but as a social good'. The White Paper adds that 'health care should be seen as a social investment and therefore should not be subjected to market forces, where it is treated as a normal commodity of trade'.

However, it is 'market forces' that create competition in the private health care system, thereby enhancing efficiency, encouraging innovation, and helping to hold down costs. This explains why South Africa's private health care system is so much more effective than the public one. It also explains why millions of South Africans, including those without medical aid, prefer to pay for private treatment rather than rely on poorly functioning public clinics and hospitals. Poor South Africans should not be deprived of this choice via the NHI system, which will effectively put an end to private health and leave all South Africans dependent on a public health care monopoly, with all its inherent inefficiency.

*The White Paper adds that 'health care should not be subjected to market forces, where it is treated as a normal commodity of trade'. However, it is 'market forces' that create competition in the private health care system, thereby enhancing efficiency, encouraging innovation, and helping to hold down costs.*

## Overview of the NHI proposal

As the White Paper makes clear, the NHI system will be implemented via a new NHI Fund, into which all health monies will be paid and from which all health expenses will be met. Both public and private monies will be pooled in this single fund. The system will also draw on the services of both public and private health facilities and health practitioners.

According to the White Paper, the NHI will reduce health care costs by imposing price controls on hospitals, clinics, doctors, specialists, medicines, consumables, and all other necessary goods and services. It will also empower the state to decide on all aspects of medical treatment, from the treatment protocols to be followed to the diagnostic blood tests to be used, the medicines to be prescribed, and the health technologies to be authorised for use.

### *Compulsory membership*

As the White Paper notes, the NHI is intended to bring universal health care coverage to South Africa. Membership of it will thus be compulsory, irrespective of whether people want to participate in it or not. Individuals will not be obliged to use the services it provides, but they will be compelled to help pay for it. In addition, since the NHI will effectively put an end to most private medical schemes (as described below), most South Africans will in practice have no choice but to rely on it.

### *Benefits to be provided*

According to the White Paper, the NHI will provide 'a comprehensive package of personal health services'. However, since resources will be limited, it will have to prioritise and 'will not cover everything for everyone'.

The White Paper nevertheless states that the NHI's 'comprehensive package' will include preventative, curative, rehabilitative and palliative health care services. It will cover HIV/AIDS and TB services, along with optometry, speech and hearing, and mental health services. Also to be included are 'prescription medicines', 'chronic disease management', and 'diagnostic radiology and pathology services'. In addition, benefits will extend to 'reproductive', maternal, paediatric, and child health services, along with emergency care.

Within this broad package, the benefits that will in fact be made available will be decided by the 'NHI benefits advisory committee'. This will 'develop service entitlements for all levels of care', from primary to quaternary (the most specialised of all hospital treatment). According to the White Paper, 'the range of services will be regularly reviewed using the best available evidence on cost-effectiveness, efficacy, and health technology assessments'. What this also means, however, is that bureaucrats will decide what should be included, while patients and even health professionals will have little or no say.

The White Paper adds that 'irrespective of how comprehensive the NHI entitlements will be, some personal healthcare services will not be covered'. Certain dental services could be excluded, for example, but these might then be covered via the 'complementary' services that medical schemes will still be allowed to provide (as further described below).

'The point of entry' will be at the primary health care level, so patients needing specialists or hospital treatment will have to be referred upwards from the primary level. Anyone who goes directly to a specialist will have to pay what the White Paper calls a 'bypass fee'.

### *The new bureaucracy required*

As the White Paper implicitly acknowledges, a host of new administrative and regulatory entities will be required to implement the NHI. A number of new monitoring and other information systems will also have to be established.

> *The benefits to be made available will be decided by the 'NHI benefits advisory committee'. This range of services will also be regularly reviewed. What this means, however, is that bureaucrats will decide what should be included, while patients and even health professionals will have little or no say.*

Under the NHI system, much emphasis will be placed on primary health care, in which municipal- and district-based teams will play a vital part. Municipal *'ward-based primary health care outreach teams (WBPHCOTs)'* will thus be established in each of the roughly 4 400 municipal wards within the country. These will be led by a nurse, linked to a clinic, and staffed by community health workers. These community health workers will assess the health status of all households within a given ward, so as to identify those in need of 'preventative, curative, or rehabilitative services'. They will then refer all those requiring health treatment to the local clinic or other primary health care facility. The White Paper sees these teams as 'a game-changer' in improving access to health care. However, all these teams will in fact be able to do is to identify health needs, rather than find ways of meeting them.

Within each of the country's 44 district municipalities, an *'integrated school health programme'* will be introduced. This initiative will seek to assess the health needs of all South Africa's school pupils, who number around 12 million in any given year. Thus far, some 70 'school mobiles' have been deployed in the ten district municipalities selected as 'pilots' for the NHI system. These mobile teams managed to assess the needs of some 500 000 pupils in 2014. This suggests that each school mobile can deal with roughly 7 100 pupils in a year. To cover 12 million pupils, some 1 690 school mobiles will be needed.

Each district municipality will also have a *district clinical specialist team*. Each such team is to have seven members, including specialists in obstetrics, gynaecology, and paediatrics. These teams will help with

capacity building and mentorship. They will also 'strengthen the use of the clinical guidelines and protocols' to be decided by various other committees (as described below). Again, the specialists in these teams will have to be paid and equipped so that they can fulfil their functions.

South Africa has close on 3 200 public clinics, each of will need a *'clinic committee'* to advise people and conduct health campaigns in its particular area. Guidelines have already been developed as to how these clinic committees should function, and these will be revised from time to time. Again, various costs will be involved in establishing these committees and empowering them to fulfil their mandate.

Each district municipality will also have a new *'district health management office (DHMO)*'. These offices will be responsible for 'managing, planning and co-ordinating personal and non-personal health service provision, taking into account national health policy priorities and guidelines as well as health needs in the district'. These health needs will presumably be determined by sifting through the data to be provided by the ward-based teams, the school mobiles, the clinic committees, and each district clinical specialist team. Properly assessing and weighing the significance of all this information will no doubt be a complex and costly task. In itself, however, it will do little to increase the supply of the health services required to meet the needs identified.

Above the primary level, there will be hospitals of six different kinds. These will range from district hospitals providing general medical services to central hospitals, providing highly- and super-specialised services. Each hospital is to have its own *hospital board*, so funds will again be needed for the remuneration and/or expenses of board members. Additional monies will be required to train board members, improve their skills, and make it possible in time to delegate more managerial autonomy to them.

Hospitals, like all other health facilities and health practitioners, will have to comply with the norms and standards set by the *Office of Health Standards Compliance (OHSC)* if they are to be accredited to participate in the NHI. The OHSC is already in existence, but will have to be expanded if it is to cope with its increased responsibilities under the NHI.

All health care practitioners and facilities will have to be assessed and certified by the OHSC before they may participate in the NHI. OHSC assessments cover 'seven domains and six national core standards'. The seven domains range from patient safety and clinical care to facilities, infrastructure, corporate governance, and operational management. The national core standards include cleanliness, staff attitudes to patients, infection control, security, waiting times, and the availability of medicines.

> *All health care practitioners and facilities will have to be certified by the OHSC before they may participate in the NHI. Once certified, they will be 'eligible for accreditation and contracting by the NHI Fund'.*

Health facilities that meet these standards will be certified by the OHSC to 'render health services', and will then be considered 'eligible for accreditation and contracting by the NHI Fund'. The actual task of accrediting and contracting with each health care provider will be carried out by another administrative entity, as explained in due course.

The OHSC already has an inspectorate to help enforce compliance with these norms and standards. However, this will need to be expanded if it is to have the capacity to certify all public and private facilities and health practitioners within the country. It also has an ombud to investigate complaints by patients – but again this will have to be extended to cope with the volume of work likely to arise once 55 million South Africans have been given the promise of 'quality' health care under the NHI.

To increase access to essential medicines and shorten queues at clinics and hospitals, a *Centralised Chronic Medication Dispensing and Distribution (CCMDD)* programme has already been introduced. The existing system has two components: Central Chronic Medicines Dispensing and Distribution (CCMDD) and Pick-up-Points (PuPs). Thus far, this programme has concentrated on providing ARVs to some 260 000

patients. However, this is a miniscule portion of the demand that is likely to arise when a total of some 7 million HIV-positive South Africans become entitled to free ARV treatment under the NHI. The existing CCMDD programme will thus have to be greatly expanded to cope with the increased demand the NHI will generate – not only for ARVs, but also for a host of other medicines.

*A National Health Commission (NHC*) will also be established to advise on health promotion and disease prevention. It will focus, among other things, on 'preventing and managing diseases of lifestyle that are likely to pose a major threat over the next three decades'. The commission will work together with government departments and other stakeholders in finding ways to curb the rising prevalence of non-communicable diseases, including cancer and diabetes.

Also required, of course, will be the *NHI Fund*, into which all monies needed for the NHI will be paid and out of which all expenses will be paid. Many bureaucratic processes will be required in the establishment and operation of this fund. As the White Paper puts it: 'The creation of the NHI Fund will entail the establishment of functional, governance and accreditation structures and purchasing systems, risk mitigation systems, health technology assessment, as well as systems for monitoring and evaluation systems.'

Given the range and complexity of these functions, the NHI Fund will have eight sub-units. These will be a *Planning and Benefits Design Unit, a Price Determination Unit*, an *Accreditation Unit*, a *Purchasing and Contracting Unit*, a *Procurement Unit*, a *Provider Payment Unit*, a *Performance Monitoring Unit*, and a *Risk and Fraud Prevention Unit.*

> *Whether or not to accredit a particular facility or practitioner already certified by the OHSC will depend on the 'health needs of the population', the 'service package' to be provided, any particular 'location requirements', and 'the routine submission of specified information'.*

The specific functions of these sub-units are generally not explained in the White Paper. Accreditation, however, will be a complex process, in which the OHSC's confirmation of eligibility for accreditation will be just the start. Whether or not to accredit a particular facility or practitioner already certified by the OHSC will depend, among other things, on the 'health needs of the population', the 'service package' to be provided, any particular 'location requirements', plus 'the routine submission of specified information'.

The information needing to be submitted will include diagnostic codes applied, drugs dispensed, diagnostic tests ordered, length of patient stays, and discharge/separation information. Any decision on accreditation will also have to take into account 'the demographic (age/sex) composition and epidemiological profile of the resident or catchment population in each district'. In addition, providers will have to be measured 'against indicators of clinical care, health outcomes, and clinical governance, rather than simply on perceived quality of service'. None of these criteria will in practice be easy to assess, which means the costs of doing so are likely to be high.

As the White Paper stresses, all service providers will be expected to adhere to mandatory treatment protocols. Some treatment guidelines have already been developed, in the form of the *Standard Treatment Guidelines associated with the Essential Drug List (EDL).* Under the NHI system, these guidelines will be 'reviewed and updated over a three-year cycle to take account of new technology and evidence'. They will be supplemented by *further guidelines*, still to be developed, which will cover surgical procedures, anaesthesia, the treatment of malignancies, and other matters. 'The *NHI Benefits Committee* will thus establish *Expert Committees* to develop guidelines for the priority areas where there are currently gaps.'

However, since clinicians might at times regard these guidelines as too inflexible, the NHI Fund will establish yet another committee, a *Clinical Peer Review Committee*, to deal with this problem. This committee will use 'transparent and accountable processes' to mitigate any perceived inflexibility and help manage

'complications or co-morbidities'.

The NHI Fund will also develop a *National Health Information Repository and Data System*. This system, the White Paper, says 'will be crucial for the implementation and effective management of the NHI and the portability of services for the population'. It will require 'an electronic platform with linkages between the NHI Fund membership database and the accredited and contracted health care providers'. It will be used, among other things, to 'monitor the extension of coverage', 'track the health status of the population', deal with 'all financial and management functions', monitor the 'utilisation of health care benefits by NHI members', provide 'quality assurance programmes', produce reports, and develop 'research and documentation to support changes as the health care needs of the population change'. An army of officials will be needed to marshal and maintain all this information for 55 million South Africans.

One component in the overall Information System will be the *Health Patient Registration System (HPRS)*. This is already in place, for it was launched in July 2013 with the help of the Department of Science and Technology and the Council for Scientific and Industrial Research (CSIR). The HPRS provides a *Patient Registry and Master Patient Index (MPI)* service, which records not only patients' identity (ID) numbers, but also their personal details and the health services given to them. Thus far, some 555 000 patients have been registered. That leaves approximately 54.5 million people still to be included in the index. Also to be created is a *Health Provider Index (HPI)*, which will help link available providers to the patients registered on the MPI.

> *According to the White Paper, 'the selection of medicines and other health technologies will be based on the burden of disease, efficacy, safety, quality, appropriateness, and cost-effectiveness'.*

As the White Paper points out, a system of *'health technology assessment'* will also have to be established. Officials engaged in this function will have to decide on the 'introduction of interventions for health promotion, disease prevention, diagnosis, treatment, and rehabilitation'. According to the White Paper, new technologies are unlikely to be approved unless officials are satisfied that they will make for a more 'efficient use of resources' in the context of 'a sustainable health system'. Expensive new cancer and other drugs are unlikely to be included in the NHI benefits package, as the key criterion will be 'whether they are more cost effective than existing health service interventions'.

The White Paper also stresses the need for *'a national health products list'*, which will set out what products are allowed at different 'provider levels'. According to the White Paper, 'the selection of medicines and other health technologies will be based on the burden of disease, efficacy, safety, quality, appropriateness, and cost-effectiveness'. Many more officials will be needed to make the numerous decisions that will be needed in this sphere. In addition, 'the list will have to be reviewed on a regular basis to take account of changes in the burden of disease, product availability, and price-changes based on evidence'. More officials will be required to carry out these regular re-assessments.

Yet another new structure will also be required, in the form of the *NHI Commission*. This body will oversee the NHI Fund and ensure (the White Paper says) that 'the NHI Fund is accountable and that the interests of the general public are taken into account'. The NHI Commission will include experts in relevant fields, including health-care financing, public health, health policy and planning, epidemiology, actuarial sciences, taxation, and ICT. It will also include civil society representatives. The NHI Fund will report on a quarterly basis to the NHI Commission and on an annual basis to Parliament. Specific performance indicators will be developed against which the NHI Fund will routinely be assessed.

### *The scale and likely outcomes of the OHSC's certification task*

According to the White Paper, the NHI will draw in both public and private health facilities and practitioners, so as to increase both the quantity and the quality of the health services to be made available to all South

Africans. The OHSC will make the initial assessment as to whether a health care facility or practitioner qualifies for accreditation, while the subsequent accreditation process will be managed by a sub-unit of the NHI Fund (as earlier outlined). However, the White Paper brushes over the scale of the OHSC's certification task. It also overlooks the key question of how many public and private facilities are in fact likely to qualify for participation in the NHI.

The OHSC, as described in *Part 1*, was established in 2013 to help improve compliance with key norms and standards at public hospitals and clinics. In 2014/15, the new office re-inspected 417 of the roughly 3 900 state facilities that a 2012 audit had found to have 'appalling' compliance outcomes. The results of this fresh inspection were again dismal, for only 3% of these facilities were found to be 'compliant'. Another 13% were compliant 'with requirements' or were 'conditionally compliant'. The remaining 84% were non-compliant, of which 16% were 'conditionally compliant with serious concerns', 28% were 'non-compliant' and 40% were 'critically non-compliant'.

Since then, the situation seems to have become still worse. Data recently prised out of the OHSC (by journalist Tamar Kahn under the Promotion of Access to Information Act of 2000), and published in *Business Day* last month indicates that a total of 1 427 public facilities have been inspected over the past four years. Of these, only 89 (6% of the total) scored 70% or more: the level identified by the OHSC as a 'pass'. Most facilities continued to fall short on such essentials as infection control and the availability of medicines.

> *More recent data from the OHSC suggests that only 6% of public facilities would qualify to participate in the NHI. Moreover, most of the facilities monitored have made little progress in improving their compliance.*

As *Business Day* reported, some 110 public hospitals and clinics in the NHI's 'pilot' district municipalities fared particularly badly. They also showed little improvement when repeat inspections were carried out, sometimes up to three or four times. Only 25 (22.7% of the total) managed to increase their scores by 20% or more, whereas clinics outside the pilot districts often showed greater improvements.

This more recent data from the OHSC is particularly disturbing, for it suggests that only 6% of public facilities would qualify to participate in the NHI. Moreover, most of the facilities monitored – and especially those in the NHI pilot districts – have made little progress in improving their compliance. But Dr Motsoaledi, interviewed by Chris Barron of the *Sunday Times* after the *Business Day* exposé, rejected any suggestion that the NHI pilot sites were failing, or that very few public health facilities would be able to take part in the NHI. According to the minister, OHSC assessments to date have been 'mock inspections', as the agency is still 'fine-tuning its systems'. Adds Dr Motsoaledi: 'The OHSC is still setting up systems and testing them. You can't take those figures and use them as a standard for whether the pilots are successful.'

The minister also ignores the magnitude of the task confronting the OHSC. The organisation still has only 35 inspectors, which is far too little for what the NHI requires. As earlier noted, South Africa has close on 3 200 public clinics, along with some 410 public hospitals and 200 private hospitals, all of which will have to be assessed once every four years to ensure their continued compliance with the relevant standards. There are also between 31 000 and 74 000 private health care practices in the country, all of which will also need to be certified by the OHSC if they are to take part in the NHI (again, with mandatory re-inspection every four years).

The number of health practitioners potentially needing OHSC certification is even higher. Registered health care professionals include some 42 300 GPs and specialists, along with roughly 6 000 dentists, 4 600 occupational therapists, 6 900 physiotherapists, and 7 800 radiographers and approximately 278 600 nurses of various kinds. Not all these registered practitioners are necessarily working in the country – and not all may wish to participate in the NHI – but the scale of the OHSC's certification task is nevertheless enormous.

This also has major ramifications for the NHI system. Unless the OHSC acquires the capacity to certify all private health care facilities and practitioners, these health resources will not in fact become available to the NHI. Unless this problem can be overcome – and unless poor compliance standards in the public sector can be sharply improved – there is a real risk that the NHI system will leave 55 million South Africans reliant on the 16% (or 6%) of public facilities that would currently merit OHSC certification. On this basis, waiting times for even the simplest medical treatments are likely to be inordinately long.

### *The role of medical schemes*

According to the White Paper, the NHI will be funded through 'mandatory prepayment' into the NHI Fund. 'Individuals will not be allowed to opt out of making the mandatory prepayment towards NHI, though they may choose not to utilise the benefits covered by the NHI Fund.' This in itself is enough to put the survival of medical schemes at risk, for many of the people who now belong to medical schemes will not be able to afford both their medical aid contributions and the additional taxes required to fund the NHI.

More seriously still, the White Paper now seeks to confine medical schemes to covering only those services that are not available through the NHI. According to the White Paper, medical schemes will play 'a supplementary role' in the period when the NHI is still being established. In this period, individuals who can afford to retain their medical aid cover will still be able to access health services in this way, even if those services fall within what the NHI covers. However, the White Paper adds, 'once the NHI is fully implemented, medical schemes will offer complementary cover to fill gaps in the universal entitlements offered by the state'.

> *As the White Paper implicitly acknowledges, restricting medical schemes to providing complementary cover is likely to sound their death knell. Premiums would be set so high that only the very rich could afford them.*

Says the White Paper: 'In future, all medical schemes will offer only complementary cover for services that are not included in the health service benefits and medicines approved by the NHI Benefits Committee. The cover provided by medical schemes must only complement (and not duplicate) the NHI service benefits.' When the NHI is fully implemented, the White Paper thus anticipates that 'the number of medical schemes will reduce from the current 83 to a much smaller number'.

As the White Paper implicitly acknowledges, restricting medical schemes to providing complementary cover is likely to sound their death knell. A medical scheme would still be able to cover a rare disease (such as haemophilia or uncontrolled bleeding), as this is unlikely to be included in the NHI package. However, the pool of potential members wanting such cover would be very small. Premiums would thus have to be set so high that only the very rich would be able to afford them. Few, if any, medical schemes would be able to survive in these circumstances.

Soon after the White Paper came out, Dr Motsoaledi seemed to distance himself from the document's assertion that medical schemes would be limited to 'complementary' cover. In an interview with *Business Day* in January 2016, the minister said: 'We are not envisaging burning medical schemes outright. The private schemes like Discovery, we don't think it will be fair for any one of us to say they are no longer going to work. We want people to make their own choice.' The White Paper had given the wrong impression, and this aspect of the document would have to be 'clarified and sharpened'. However, in an address to the Competition Commission's Health Market Inquiry in March 2016, the minister backtracked on his earlier suggestion. When the NHI was fully functional, he 'wouldn't know any justification' for GEMS and other medical schemes to continue to exist, he said.

### *Compelling the participation of private practitioners*

If medical schemes are confined to providing 'complementary' services and largely collapse as a result, few South Africans will be able to afford private health care. This in itself will put great pressure on private

practitioners to participate in the NHI, even though the capitation fee envisaged – which will be the same in both the public and the private sectors – is unlikely to cover the many overhead costs of maintaining a private practice.

However, the participation of private practitioners could also be achieved in another way: by making operative a chapter in the National Health Act of 2003 which already requires a 'certificate of need' for the provision of 'prescribed health services', the establishment of any new 'health establishment', and the 'continued operation of any health establishment'. Once these provisions are brought into effect, all private doctors, specialists, and other health care professionals will require a certificate of need from the government to establish or maintain their practices. So too will all private hospitals and clinics.

The decision whether or not to grant a certificate of need will rest with the director general of health. In making this decision, he must take into account 'the epidemiological characteristics of the population to be served', along with the need to 'promote an equitable distribution…of health services' and 'correct inequities based on racial,…economic, and geographical factors'. These criteria are so vague as to give the director general and his officials a large measure of discretion in applying them.

'Since there will be no objective way to decide these issues, decisions will ultimately be based on ideological and political expediency,' notes the Free Market Foundation. Once the NHI comes into force, private health professionals reluctant to participate in the new system could well find that their applications for certificates of need are either rejected, or granted solely for remote rural areas where they have little wish to practise. In addition, any appeal against the director general's decision will lie to the minister of health, rather than the courts. This situation could also put great pressure on private health professionals to subject themselves to the NHI.

*Once the NHI comes into force, private health professionals reluctant to participate in the new system could well find that their applications for certificates of need are either rejected, or granted solely for remote rural areas where they have little wish to practise. In addition, any appeal against the director general's decision will lie to the minister of health.*

In 2014 the certificate-of-need provisions came closer to being implemented, President Jacob Zuma bringing the relevant clauses into operation by proclamation in the *Government Gazette*. This meant that all private health establishments, from GPs to hospitals, were now obliged to obtain such certificates. However, it also transpired that vital regulations clarifying the criteria and processes to be applied in granting these certificates had yet to be gazetted. This meant that nobody could obtain the necessary certificate. Private health professionals continuing to practise without it were nevertheless in breach of the law and vulnerable to criminal prosecution. Mr Zuma was thus compelled to apply to the Constitutional Court for an order setting his proclamation aside. This order was granted in January 2015.

Dr Motsoaledi quickly made it clear that he still intended to press on with the certificate-of-need provisions, which he saw as 'part of the National Health Insurance white paper'. Hence, the fact that the provisions had been withdrawn did not mean that they had been scrapped. Said Dr Motsoaledi: 'You will need a certificate of need to practise and we are going ahead with it. The reason we withdrew it was because it was badly written. I don't understand why people are seeing it as a monster.'

The White Paper itself makes no reference to the certificate of need. It remains, however, a potent weapon in the hands of the state to compel private health professionals to participate in the NHI. However, the practical outcome may nevertheless be different from what the ANC envisages.

Even if health professionals are willing to sign up for the NHI, the under-resourced OHSC may not in fact have the capacity to certify the tens of thousands of private practices in the country. Since OHSC certification is essential for NHI accreditation, in practice this obstacle could bar many practitioners from taking part

in the NHI. In addition, many private doctors, specialists and other health professionals may be unwilling to participate in a health system which pays them poorly and often only after long delays (see *Part 3*), fails in practice to supply the medicines and other goods and services needed to treat the sick, and controls every aspect of the health services they are permitted to provide, irrespective of what their own knowledge and experience would suggest. Many practitioners may thus prefer to emigrate. This will reduce the health services available to 55 million South Africans just as the NHI hugely increases the demand for them.

# PART 3: NHI COSTS AND CONSEQUENCES

**The White Paper assumes that the NHI will usher in a cost-effective system of state-controlled health care in which all South Africans will indeed obtain quality health treatment whenever they require it. The more likely consequence, however, is that demand will far outstrip supply and that almost all South Africans will wait long periods for treatment. This is what has happened in Canada, which has a single-payer system of universal health care similar in many ways to what the White Paper proposes. Access to treatment is also likely to remain unequal, for the wealthy and well-connected will be better placed to jump the long queues.**

**Though medical treatment will be free at the point of delivery, the overall costs of the NHI are likely to be enormous. The White Paper makes little attempt to quantify what NHI benefits might cost to provide. It also overlooks what the massive NHI bureaucracy will cost to staff and run. Its belief that price controls and centralised procurement will increase efficiency and hold down costs is flawed and unconvincing. So too is its suggestion that its 'risk mitigation' exercises will be effective in preventing corruption, fraud, and theft. Its assessments of how the 'pooling' principle will work – and of the tax increases needed to fund the NHI – are superficial and mistaken. It also ignores the ideology underpinning the NHI proposal, and the many ways in which the NHI will contradict the Constitution.**

The White Paper under-estimates the costs of the proposed NHI and overlooks the many negative consequences the new system is sure to usher in. It ignores the lengthy waiting times likely to arise and assumes that access will be equal, when this will not be so. It looks to price controls to bring down costs, while discounting the inefficiency and corruption that the system will promote. It fudges the difficult question of how the necessary funds are to be found, and ignores the ANC ideology that provides the real reason for the introduction of the NHI. It also simplistically assumes that the NHI will be in keeping with the Constitution, when this is not the case.

*The White Paper under-estimates the costs of the proposed NHI and overlooks the many negative consequences the new system is sure to usher in. It ignores the lengthy waiting times likely to arise and assumes that access will be equal, when this will not be so.*

## Long waiting times, especially for the poor

The NHI proposal is similar in various ways to the national system of universal health care introduced in Canada in 1984. The comparison is not a perfect one, however, for the Canadian system has many advantages compared to the South African proposal. To begin with, Canada is a developed country with far higher GDP per capita, much lower unemployment, and a far bigger tax base than South Africa. Second, the Canadian system is not truly a single-payer one, in the way the NHI will be, as the task of administering its health care system is divided among its ten provinces. Third, though Canada has prohibited hospitals

and doctors from accepting fees from patients for medical services covered by their single-payer system, it has not put an end to private medical schemes, private hospitals, or private practices in the way South Africa intends. Hence, as the shortcomings of Canada's universal health care system have become more apparent, so the use of private facilities has increased. In addition, the proximity of the US provides a vital safeguard, with more and more Canadians crossing the border to obtain medical treatment there. Implicitly, the Canadian government now sanctions this option, with seven of the ten Canadian provinces sending some of their breast and prostate cancer patients to the US for radiation therapy.

Despite these relative advantages, the Canadian universal health care system has failed to live up to the promises that accompanied its introduction. When the changes were being debated, great emphasis was placed on the need for equality and how the new system would achieve this. Instead, however, the Canadian health system has persistently proved unable to meet patient demand. The upshot has been long waiting times for medical treatment, which have steadily increased over time. These lengthy waiting periods have also affected the poor the most, as the wealthy and well-connected have often found ways to jump the queues.

> *The median waiting time from GP to specialist in the first segment increased from 8.5 weeks in 2015 to 9.4 weeks in 2016. As the Freser Institute points out, 'this wait time is 155% longer than in 1993, when it was 3.7 weeks'.*

The Canadian system, like the proposed NHI, requires patients to start by seeing a general practitioner (GP), who must refer them to a specialist where this seems necessary. Often, however, the patient must wait weeks or months to see that specialist. Following this consultation, the patient must frequently wait further for diagnostic tests and thereafter for the surgery or other treatment indicated. The two most important waiting times in this process are (1) the period from referral by a GP to consultation with a specialist, and (2) the period from this consultation to the time of treatment. Both periods have grown very much longer since the system was introduced. This is readily apparent from an annual monitor which the Fraser Institute, a Canadian think-tank, has been conducting for more than 20 years.

According to the Fraser Institute's 2016 survey, the median waiting time in the first segment increased from 8.5 weeks in 2015 to 9.4 weeks in 2016. As the Institute points out, 'this wait time is 155% longer than in 1993, when it was 3.7 weeks'. Median waiting time in the second segment went up from 9.8 weeks in 2015 to 10.6 weeks in 2016. Comments the Institute: 'This wait time is 88% longer than in 1993 when it was 5.6 weeks. It is also more than three weeks longer than physicians consider clinically "reasonable".'

These long waiting times in Canada contradict the White Paper's assumption that the NHI will give all South Africans effective access to quality health treatment whenever they require it. They also contradict the NHI's emphasis on equality, because waiting times are not the same for everybody. To begin with, waiting times vary geographically, from one province to another. In 2016, for example, overall waiting times (from referral by GP to treatment) ranged from a low of 15.6 weeks in Ontario to a high of 38.8 weeks in New Brunswick. Overall waiting times also vary according to the type of treatment required: in 2016, waiting periods ranged from 3.7 weeks for medical oncology to 46.9 weeks (more than ten months) for neurosurgery and 38.0 weeks (over eight months) for orthopaedic surgery.

In addition, waiting times have variable impact. Some patients may simply be inconvenienced by having to wait for treatment, but others wait in great pain and mounting anxiety. For some, long waiting periods involve the risk of becoming irreversibly ill before treatment can be obtained. A significant proportion of patients have to give up on treatment altogether, because long waits leave them too sick to undergo surgery with a reasonable risk of survival. At worst, of course, some patients die while waiting for their turn.

Writes the Fraser Institute: 'Research has repeatedly indicated that wait times for medically necessary

treatment are not a benign inconvenience. Wait times can, and do, have serious consequences such as increased pain, suffering, and mental anguish. In certain instances, they can also result in poorer medical outcomes – transforming potentially reversible illnesses or injuries into chronic, irreversible conditions or even permanent disabilities.' Economic costs arise as well, for patients who are gravely ill often have to go without their salaries while they wait for treatment. This is a further source of individual suffering for them. Their reduced spending power and limited productivity also harms the wider economy.

Moreover, despite the promise of equality via Canada's single payer system, socio-economic status continues to play a part in who waits less and who waits longer. Back in 1998, for instance, as US health expert Dr John Goodman records, 'a survey of Ontario physicians found that more than 80% of physicians, including 90% of cardiac surgeons and…60% of family physicians, had been personally involved in managing a patient who received preferential access on the basis of factors other than medical need. When asked about those patients most likely to receive preferential treatment, physicians reported that 93% had personal ties to the treating physician, 85% were high-profile public figures, and 83% were politicians'. A similar phenomenon is sure to arise in South Africa, where the poor and marginalised will wait the longest – and the politically connected will be able to jump the queue.

In Canada, the equality goal is also undermined in another important way. As Dr Goodman writes, its universal health care system in practice 'tends to encourage routine medical services for the vast majority of people who are healthy at the expense of specialised care for the few who are seriously ill'. This is partly, of course, in keeping with the country's emphasis on primary care. It is also reinforced via restrictions on sophisticated health technologies and the number of doctors permitted to qualify as specialists. However, the divergence in the treatment made available also reflects a powerful political imperative. The millions of healthy people needing primary medical treatment are more important at election time than the relatively few requiring advanced medical interventions. In practice, this counts more than the equality principle.

*Wait times can, and do, have serious consequences such as increased pain, suffering, and mental anguish. In certain instances, they can also result in poorer medical outcomes.*

The White Paper overlooks these practical considerations. It also glosses over how much the NHI is likely to cost, which cannot be quantified without clarity on a host of issues. These include the extent of the benefits to be provided, the size of the new bureaucracy required, and the likely impact of price controls, centralisation, and corruption.

## Quantifying the likely costs of the proposed NHI

### *How much are NHI benefits likely to cost?*

The White Paper is vague as to what the 'comprehensive' benefits to be provided by the NHI will be. As earlier noted, it acknowledges that the NHI cannot 'cover everything for everyone', but it also stresses the wide range of health services the new system is intended to provide.

The White Paper dismisses the need for accurate forecasting of the likely costs of the NHI, saying 'it is not useful to focus on getting the exact number indicating the estimated costs'. Countries which have tried this, it adds, have 'ended up tied to an endless cycle of revisions and attempts to dream up new revenue sources'. Hence, 'the question of "what will the NHI cost" is the wrong approach', it says. Yet the issue of what the NHI will cost must be addressed if the affordability of the proposal is to be assessed.

Dr Motsoaledi has also rejected the need for accurate cost estimates, saying that what the NHI costs will 'depend entirely on how we design it'. This means that 'it could cost anything up to R1 trillion', depending on how it is planned. As the minister indicates, the more benefits are included in the NHI, the more expensive the new system will be.

In 2009, when the ANC released a 200-page discussion paper on the NHI, Dr Jonathan Broomberg,

chief executive of Discovery Health, said: 'If the NHI were to provide the current package of benefits provided to the average member of a medical scheme to the entire population, this would currently cost about R497bn, equivalent to 20% of GDP'. This cost estimate was provided seven years ago. Hence, if these are indeed the benefits to be provided by the NHI, Dr Broomberg's estimate needs to be increased by at least 45%, as this is the overall percentage increase evident in public health care spending over the past five years. This would bring the total to R720bn. This is roughly equivalent to 18% of South Africa's GDP in 2015, which amounted to R3 990bn.

NHI benefits might instead be limited to the prescribed minimum benefits (PMBs) which the government requires medical schemes to provide to all their members. At present, medical schemes need around R600 per person per month to cover the PMBs. On this basis, the cost of providing these benefits to 55 million South Africans would be R396bn in this financial year.

### *What about the costs of the NHI bureaucracy?*

The costs of the major bureaucracy that will be needed to implement the NHI must also be taken into account. This issue is not covered in the White Paper and its likely costs are, of course, also difficult to quantify. However, all of the new administrative entities envisaged (as set out in *Part 2*) will have to be suitably staffed, remunerated, equipped, and provided with appropriate office or other working space.

How big will these new entities be? This is difficult to judge, but let us start by assessing the likely needs of the Provider Payment Unit, which is one of the eight sub-units to be established within the NHI Fund. Though it may have other functions too, its key task will be to make all the payments that will be due to hospitals, clinics, doctors, specialists, nurses, and other professionals for the health services they have provided to patients without charge.

> *If the NHI were to provide the current package of benefits provided to the average member of a medical scheme to the entire population, this would currently cost about R720bn, equivalent to 18% of South Africa's GDP.*

The experience of the statutory Compensation Fund provides some guidance here. The Compensation Fund receives the mandatory 'workmen's compensation fees' which most employers and their staff are obliged to pay to compensate employees who are injured at work. From these monies, the Compensation Fund pays the medical fees of the doctors and specialists who have treated injured employees. It also pays out compensation to the employees themselves. The fund receives roughly R8bn a year in income (and has reserves amounting to some R53bn).

Between 2012 and 2015, the Compensation Fund paid out claims amounting to between R1.4bn and R2bn a year. This provides some insight into the magnitude of the task confronting the Provider Payment Unit and the number of staff that it might need. Writes Dr Johann Serfontein of the HealthMan consultancy: 'The Compensation Fund employs 1 630 people, who paid out R1.4bn in medical claims in 2015. By comparison, Discovery Health, with five times this number of employees, paid out 26 times the amount in medical claims. The required NHI budget is estimated by the White Paper at R256bn a year, which is 32 times larger than the size of the Compensation Fund's annual income of R8bn. The number of claims payable is likely to be 100 times more (not including the payment of suppliers). Using the Compensation Fund efficiency as a barometer, this will require [the Provider Payment Unit of] the NHI Fund to employ between 52 000 and 160 000 people.'

The Provider Payment Unit may also be given the task of paying for all the medicines, consumables, medical devices, medical equipment, diagnostic tests, and other goods and services that will be needed in meeting the health requirements of some 55 million South Africans. If this is indeed the case, the unit may require a further 52 000 to 160 000 officials to handle this aspect of the payment process. Providing salaries, pensions and other benefits to all these new employees will not come cheap. It could in fact cost in the

region of R60bn, as the South African Private Practitioners' Forum (SAPPF), has estimated. Yet the Provider Payment Unit is only a small part of the overall bureaucracy that will be needed to administer the NHI.

Proponents of the NHI are silent about the size of the bureaucracy required, how much it will cost, and how inefficient it might be. Instead, they simplistically claim that the NHI will help to bring down costs and be much cheaper than the current system, the costs of which they constantly castigate. However, as world-renowned public intellectual Professor Thomas Sowell of Stanford University has observed: 'It is amazing that people who think we cannot afford doctors, hospitals, and medication somehow think that we can afford doctors, hospitals, and medication – and a government bureaucracy.'

### *How much will price controls and centralised procurement reduce costs?*

The White Paper assumes that the NHI system will succeed in bringing down health care costs in various ways. First, all medical practitioners, including those in the private sector, will be reimbursed on a capitation basis (a fixed amount per person treated), rather than accorded a separate fee for every service rendered. In addition, a centralised procurement system for diagnostic tests, pharmaceuticals, and other goods and services will supposedly generate economies of scale, while the prices of medicines and all other items will be strictly controlled. These measures may succeed to some extent in shifting costs from consumers to the providers of goods and services, but they will also result in major and expensive inefficiencies.

### *State-controlled fees for health providers*

According to the White Paper, the NHI Fund 'will determine its own pricing and reimbursement mechanisms' in consultation with the minister. Payments to health care practitioners and facilities will be calculated on a 'risk-adjusted capitation formula', which will be based on factors such as population size and the 'age, gender, and disease/epidemiological profile' of the area, as well as 'target utilisation and cost levels'. To ensure that capitation fees do not result in under-servicing, providers will have to adhere to the treatment protocols laid down by officials. There will also be 'routine monitoring of provider practices', through 'peer review at the district level and monitoring by the NHI Fund'. Deciding on the amount of capitation fees – and on whether providers deserve to be paid them in full – will thus be a complex task.

*Capitation fees for health practitioners will be the same irrespective of whether they are working in publicly- or privately-owned facilities. But those with private practices must cover a host of overhead expenses from which people working in the public service are shielded. Hence, the fees set by the NHI Fund might 'lead to providers closing shop'.*

Where services are purchased from specialists, the NHI will use 'a capped case-based fee, adjusted for complexity where appropriate'. This too will be 'continuously reviewed', taking account of issues such as 'access and budgets'. Payments to hospitals will increasingly be based on 'case-mix adjusted payments, such as diagnostic-related groups'. (Such a system classifies patients according to their diagnosis and sets a single fee for treating these conditions.) In time, the emphasis will move towards 'global budgeting' based on 'crude activity estimates' and 'unit costs for different levels of care'.

As earlier noted, capitation fees for health practitioners will be the same irrespective of whether they are working in publicly- or privately-owned facilities. But those with private practices must cover a host of overhead expenses from which people working in the public service are shielded. Hence, the fees set by the NHI Fund might be too low to cover practice expenses and could (as Dr Serfontein warns) 'lead to providers closing shop'. The government might hope that doctors and specialists in this predicament will respond by joining the public service. However, they could also decide to emigrate instead.

### *State controls over diagnostic tests, medicines, and all other health products*

In dealing with diagnostic tests, the White Paper urges increased controls over the National Health Laboratory Service (NHLS) to prevent 'unnecessary' tests and reduce fees. This will be done by 'categorising the

127 tests' currently most commonly used and restricting the tests that may in future be carried out, based on new 'evaluation criteria'. Tests which do not meet these criteria will be rejected. A capitation-based reimbursement model will also be applied, in terms of which 'the cost per test will be adjusted against the demographic (or disease) profile of the specific province, giving a cost per person for laboratory services'. Once these controls are in place, long delays in obtaining essential diagnostic test results (some of which will be denied altogether) and inadequate funding for the NHLS are likely to result.

Price controls for medicines and health products will also be implemented. As the White Paper puts it, 'a formulary listing the prices of medicines and health products will be established nationally'. Centralised procurement of all 'health-related products, including medicines, devices, equipment, consumables, and other products' will also be introduced. According to the White Paper, this will generate significant economies of scale, while 'the advantages of price determination could save millions of rands every year'.

These price controls could also, of course, cut patients off from a host of medicines and other medical products costing more than the state is prepared to pay. Such risks are evident in Canada, which also tries to reduce the cost of medicines via price controls and formularies. Under the country's 'reference price system', officials can also require that a patient be treated with a cheaper medicine – even if it is a different compound – provided it is 'deemed' to have the same therapeutic effect. Such substitutions have frequently harmed patients. Writes Dr Goodman: '[In one study,] 27% of physicians in British Colombia reported that they had to admit patients to emergency rooms or hospitals as a result of the mandated switching of medicines.'

Price controls have also cut many Canadians off from the newest and best available medicines. Again, this has major implications for health outcomes, as research has repeatedly shown that appropriate medicines are particularly effective in treating disease and reducing the need for hospitalisation and surgery. Newer medicines are often also much more effective than older and less expensive ones. Hence, as Dr Goodman records, 'research by Columbia University professor Frank Lichtenberg indicates that each dollar spent on drugs is associated with roughly a four-dollar decline in spending on hospitals. Furthermore, ...substituting newer for older drugs...reduces spending on hospitalisations and doctor visits by 7.2 times as much as it increases drug expenditure'.

> *The White Paper assumes that price controls in all these spheres will succeed in bringing down costs and promoting efficiency. However, some prices could in fact be set too high (to assist BEE businesses, for example), while others will be set too low to maintain supply.*

The White Paper ignores these factors. Instead, it simplistically assumes that price controls in all these spheres will succeed in bringing down costs and promoting efficiency. However, since the government will dictate prices in all the spheres outlined above, market mechanisms will no longer be available for this purpose. This means that some prices could in fact be set too high (to assist BEE businesses, for example), while others will be set too low to maintain supply. In addition, without a market mechanism to assess the extent of demand, bureaucrats will have to decide on what services, medicines, and other goods will be needed when and where. Inevitably, there will be over-provision in some areas and under-provision in others. This will generate huge inefficiencies in the system as a whole, which will add to costs rather than reduce them.

### *The likely impact of fraud, corruption, and inefficiency*

One of the eight sub-units within the NHI Fund will be a Risk and Fraud Prevention Unit. According to the White Paper, this will be needed to counter damaging conduct of various kinds, including:

- 'the abhorrent provider behaviour' and 'corrupt activities' which 'the trust relationship' between doctors and their patients makes possible;

- the risk that patients could abuse the system by using fake IDs, seeking second opinions, or 'visiting facilities for minor health problems';
- the possibility that doctors could make 'excessive use of medical equipment or drugs by not following recommended treatment guidelines'; and
- the danger that pharmaceutical companies could give doctors incentives to use their drugs or to 'over-prescribe'.

The White Paper more briefly acknowledges that NHI bureaucrats and hospital staff might not be blameless either. 'Suppliers might bribe officials to overcharge for their services in return for kickbacks', it says, while managers might 'award contracts to inappropriate or unaccredited providers, or issue fraudulent NHI cards to non-beneficiaries'. In addition, staff at hospitals and other facilities could 'help themselves to medicines, linen and other supplies', causing further losses.

To guard against these dangers, the White Paper proposes a comprehensive risk management process, involving 'seven risk management steps'. The first step will be to appoint 'a risk management co-ordinator and a risk management committee'. An 'approach for risk management' will be developed (the 'NHI risk engine'), which will be supplemented by 'a risk assessment matrix', 'a risk register', and 'a risk management framework'. Risk management will also be incorporated into performance monitoring, while 'a pro-active risk identification and fraud prevention strategy will be developed to capture those who engage in fraudulent activities'.

*These paper exercises, the White Paper seems to assume, will be enough to counter fraud and other abuses. However, the more likely outcome is that losses from corruption and inflated prices in the centralised NHI system will be substantial. Already, some 40% of the government's R600bn budget for goods and services is compromised through 'inflated prices and fraud'.*

These paper exercises, the White Paper seems to assume, will be enough to counter fraud and other abuses. However, the more likely outcome is that losses from corruption and inflated prices in the centralised NHI system will be substantial. Already, as Kenneth Brown, chief procurement officer at the National Treasury, has warned, some 40% of the government's R600bn budget for goods and services – amounting to roughly R240bn a year – is compromised through 'inflated prices and fraud'. Once hundreds of billions of rands are added to the state's procurement spending via the NHI system, the scope for such abuses will greatly increase – while the bureaucratic counter-measures outlined in the White Paper are unlikely to prevent them.

Former finance minister Nhlanhla Nene (now an adviser to Thebe Investment Corporation) has recently warned that fraud in the private health care sector is also rife. Speaking at a conference in July 2016, Mr Nene said 'it was general knowledge that fraud is an "endemic" problem' in the medical scheme sector – and that it costs the industry an estimated R19bn a year. If private medical scheme administrators cannot stamp this problem out, the NHI Fund is most unlikely to succeed in doing so.

Even if fraud and corruption can be countered effectively, the problem of inefficiency is likely to remain. The example of the Compensation Fund is again relevant here, for the fund has often failed to pay out on claims in time. So bad is the problem of non-payment that hospitals have begun turning Compensation Fund patients away. In 2009, moreover, a company representing unpaid doctors obtained a High Court order instructing the fund to make the payments due. Yet the problem of non-payment still remains. In April 2015 Parliament was thus informed that the fund had yet to pay out on 231 000 outstanding claims, with an overall value of some R23bn. Some of these claims dated back ten years. This backlog was supposed to have been cleared within two months, but progress has again been slow – with only R2.6bn in medical claims paid out in 2015/16, for instance.

The inefficiency displayed by the Compensation Fund over many years illustrates the problems that are likely to arise when the NHI Fund is introduced. The NHI Fund will have a much bigger job to do, for it will be responsible for paying for all the health services provided by all accredited hospitals, clinics, doctors, specialists, nurses, and other health professionals to some 55 million South Africans. It will also have to pay for every single one of the medicines, medical devices, diagnostic tests, consumables, and other relevant goods and services that may be supplied to the population in any given year. The Compensation Fund has failed to deal effectively with a far smaller number of claims. Imagine, then, the inefficiency and inordinate delays that are likely to arise when the NHI Fund has to start paying out on hundreds of millions of claims each year.

Some concrete numbers may help to illustrate the point. Once the NHI has been introduced, every South African might take advantage of its 'free' services to consult a GP twice in a year, and might each time be provided with a single medicine. The NHI Fund would then have to pay out four times for each person, giving it a total of 220 million payments to process in that year. In practice, given South Africa's heavy burden of disease and high level of trauma cases, the number of payments needing to be made each year will be very much greater.

The inevitable result will be long delays in paying doctors and other health practitioners. As Dr Serfontein has noted, if the NHI Fund manages to pay as efficiently as the Compensation Fund now does (which seems too optimistic), doctors will often wait 70 days to be paid for services they have already provided free of charge to patients. This will make it very difficult for them to manage their overhead costs and keep their practices operating. Again, the government seems to assume that health professionals prejudiced in this way will simply join the public service – but their preference might be to emigrate instead.

*The NHI Fund will be responsible for paying for all the health services provided by all accredited hospitals, clinics, doctors, specialists, nurses, and other health professionals to some 55 million South Africans. It will also have to pay for every single one of the medicines, medical devices, diagnostic tests, consumables, and other relevant goods and services supplied.*

If the NHI Fund is also late in paying suppliers, this will have enormous impact on the performance of all hospitals, clinics, and other health facilities. Already, persistent failures to pay suppliers on time have left many public clinics and hospitals without sufficient medicines, consumables, medical equipment, and other essential items. Under the NHI system, such problems will extend into privately-owned hospitals and practices as well, making it equally difficult for them to provide a proper service.

Persistent payment delays have already done much to scupper the success of the public clinics participating in the NHI's ten pilot districts. These clinics have been singled out for special financial and other assistance from the government, so as to help improve their performance in preparation for the NHI. Yet many of the GPs working at such clinics in Tshwane, the NHI's biggest pilot district, are angry and frustrated at the practical obstacles they encounter on a daily basis.

Some of these GPs complain of persistent 'drug stock-outs and staff shortages', saying these have 'reduced them to nothing more than glorified nurses'. All they can provide are 'routine services such as blood and urine tests, blood pressure monitoring, and the dispensing and packaging of medication'. Despite the NHI's emphasis on primary care, they also find themselves having to make 'unnecessary referrals to hospitals for minor procedures that GPs would be able to deal with if they had sufficient equipment'. Such problems have left them 'embarrassed and powerless about their inability to provide decent care'. It has also made many of them determined to leave the pilot clinics as quickly as they can.

The White Paper brushes over these issues – but the likelihood of widespread corruption, fraud, and inefficiency cannot simply be ignored. Unless these problems can be overcome, they will not only erode

the medical services available to South Africans but also add substantially to NHI costs. At the very least, litigation against the Fund to recover unpaid bills could become common, adding legal costs to the overall financial burden. Major claims for damages against the Fund are also likely if, for instance, essential medicines cannot be timeously provided because suppliers have not been paid.

## The financing of the NHI

The White Paper seems to assume that the NHI can successfully be financed via the 'pooling' principle, in terms of which all health care monies will be paid into the NHI Fund. It acknowledges that tax increases will be needed to defray costs, but underestimates both the revenue required and the magnitude of the additional taxes likely to be required.

> *The minister seems to assume that the government will easily be able to extract from a relatively small pool of taxpayers as much as they now voluntarily spend (some R189bn) on the effective and efficient private health care of their choice. The White Paper suggests that those who currently belong to medical schemes must be willing to do this as part of an essential social solidarity.*

### *The 'pooling' concept and its likely ramifications*

According to the minister, the NHI system can easily be funded by 'pooling' together all the health care monies that are currently located in the public and private sectors and various other funds. 'The power of pooling means that we can afford to insure all our people,' says Dr Motsoaledi. Dr Humphrey Zokufa, managing director of the Board of Healthcare Funders, agrees, adding: 'At the moment, the health rand is fragmented. It is stretched between the nine provinces, the Road Accident Fund, Occupational Health, and 83 medical schemes. It is the role of the government to intervene here…and make sure that we pool the money for health care.'

Treasury figures cited in the White Paper put the public health care budget at R183bn in 2016/17. In the same period, total spending on private health care (mostly in the form of contributions to medical schemes) is expected to come in at R189bn. This gives a combined total of R372bn which could theoretically be made available to fund the NHI system.

Dr Zokufa seems to think that monies in the Compensation Fund, coupled with those in the Road Accident Fund, could further swell the amount available for the NHI. But this overlooks the fact that the Compensation Fund still has some R20bn in outstanding claims to settle. In addition, the Road Accident Fund, according to its most recent annual report, confronts an unfunded liability of some R145bn. The Road Accident Fund, in particular, could thus drain the funds available to the NHI rather than increasing them.

The pooling principle also depends on the national health department being able to strip all provincial administrations of their present role in providing health care services. But the Constitution gives these nine administrations – which spend the bulk of the public health care budget (R160bn out of R183bn in 2016/17) – a jurisdiction over health services which is 'concurrent' with that of the national department. Transferring the bulk of provincial health functions and funds to the NHI is thus likely to require a constitutional amendment.

The minister and Dr Zokufa also seem to assume that the government will easily be able to extract from a relatively small pool of taxpayers as much as they now voluntarily spend (some R189bn) on the effective and efficient private health care of their choice. The White Paper suggests that those who currently belong to medical schemes must be willing to do this as part of an essential social solidarity.

However, standards of health care are likely to go down sharply once the government controls every aspect of the system: from the treatment protocols to be applied to the medicines and other goods to be provided. In addition, demand for health services will expand so much that long delays in obtaining treatment – far worse than those experienced in Canada – are likely to become endemic. Yet efficient health care

is vital to South Africa's middle class, both established and emerging. Many of the country's high earners, whose scarce skills are in demand in other countries too, could thus decide to emigrate. They will then not be available to contribute to the NHI (or to any of the government's other spending needs, from education to social grants and public service wages).

Emigration by individuals within this group could also have major implications for South Africa's small tax base. According to the South African Revenue Service, some 62% of South Africa's personal income taxes are paid by about 560 000 individuals who earn more than R500 000 a year. If a mere 250 000 of them were to emigrate, this could cut South Africa's personal income tax revenue by more than a quarter. This would create serious funding issues for the government in all categories of spending.

Increased emigration could also have major implications for future economic growth. South Africa confronts a major skills shortage, which the failing school system has long proved unable to address. Hence, the emigration of even 200 000 highly skilled individuals would also have a major impact on the skills base and the economy's capacity to grow.

At the same time, the pooling principle cannot in fact bring down the costs of health services, as the minister has claimed. Writing in the *Sunday Times* in June 2016, Dr Motsoaledi said that the country had 'managed to make HIV/AIDS care more affordable by combining all South Africans into one purchasing pool'. The minister went on: 'Back [in 2002], it used to cost almost R10 000 per person to buy first-line drugs to treat someone with HIV/AIDS. Today it costs the government R1 728 per person per year.'

*Some 62% of South Africa's personal income taxes are paid by about 560 000 individuals who earn more than R500 000 a year. If a mere 250 000 of them were to emigrate, this could cut South Africa's personal income tax revenue by more than a quarter.*

However, this analogy is flawed in various ways. The costs of ARVs have come down partly through economies of scale (for treatment now extends to some 3.5 million people), and partly because pharmaceutical companies have been willing to cut their prices sharply to help counter the pandemic. What matters too is that the manufacturing of ARVs does not require much skilled labour, whereas the provision of health care does. Writes Dr Serfontein: 'Health-care provision…is labour-intensive, with costs linked tightly to the human resource component.' Since the pooling of resources in the NHI Fund will not solve this problem, the minister will instead depend on price controls to reduce costs. But if these controls cut too deep, doctors will no longer be able to cover their overhead costs and will be forced to close their doors. This will worsen the imbalance between demand and supply, lengthen waiting times, and give the middle class yet more reason to emigrate.

### *The White Paper's cost projections and funding proposals*

The pooling principle suggests that NHI costs – assuming the system were to be fully implemented this financial year – would be R372 billion, as this is the combined total of projected public and private health care spending in 2016/17. This figure is relatively close to R396bn a year the NHI would currently cost if cover for the 300 or so PMBs (at R605 per person per month) were to be made available to 55 million South Africans. However, the White Paper shies away from such numbers, instead asserting that 'total NHI costs in 2025 will be R256bn (in 2010 terms)'.

This projection ignores the fact that the rand has depreciated by 26% since 2010, which has significantly increased the costs of imported medicines and equipment. The R256bn figure is also based on the assumption that 'NHI expenditure will increase by 6.7% a year in real terms after 2015/16'. According to the White Paper, such increases would 'take the level of public health spending from around 4% of GDP currently to 6.2% of GDP by 2025/26, assuming that the economy grows at an annual rate of 3.5% of GDP'. On this basis, the NHI funding shortfall would fall somewhere between R28bn and R108bn, depending on how fast budgeted revenues for health care were in fact to expand.

The White Paper's assumption that the economy will grow by 3.5% of GDP a year is based on the earlier Green Paper on the NHI. It thus overlooks the fact that a 3.5% growth rate was last attained in 2011. In 2014, the growth rate was down to 1.5% of GDP, while in 2015 it was down still further at 1.3% of GDP. In 2016, the growth rate is unlikely to exceed 0.5% of GDP and might be lower still. The White Paper's belief that economic growth at 3.5% of GDP a year will help cushion the country from the rising costs of the NHI is thus deeply flawed.

The White Paper also assumes that 'declining medical scheme contributions can be offset by a rise in general tax allocations to be directed towards the NHI'. It identifies three possible sources of increased tax revenue: a surcharge on personal income tax, a payroll tax, and an increase in the rate (14%) at which Value Added Tax (VAT) is levied. However, additional taxes of these kinds could have adverse economic consequences, as the White Paper acknowledges. Payroll taxes could reduce employment, it says. VAT is a regressive tax, so an increase in the VAT rate might place a disproportionate burden on the poor. That leaves a surcharge on personal income tax, where the highest marginal rate has recently been raised to 41%. But increasing the tax rate here could also have negative effects as it would reduce 'disposable income, consumption expenditure, and economic activity'.

Having assumed that the revenue shortfall will be R79.1bn (an unrealistic figure), the White Paper goes on to suggest this sum could be covered through a 1% payroll tax, coupled with a 1 percentage point increase in the marginal rate of personal income tax, and a 1 percentage point increase in the VAT rate. Alternatively, it says, the shortfall could be met via a 4 percentage point increase in the marginal rate of personal income tax. These projections are misleading, however, as these mooted tax increases are more likely to generate R50bn than the R79bn (minimally) required.

*Let us assume that the NHI is introduced in full in the current financial year, at a conservative cost of R372bn. From such a base, NHI costs are likely to rise by 45% to R539bn in 2021, by a further 45% to R782bn in 2026, and then by a further 45% to R1 134bn in 2031.*

Given the obvious shortcomings in the White Paper's figures, Econex, an economics consultancy, has remodelled them using more realistic economic growth projections, among other things. On this basis, it concludes that the revenue shortfall could well be R210bn when the NHI comes into operation. A funding gap of this size will not be easy to bridge.

Important too is the question of how much the NHI is likely to cost five, ten, and 15 years after its start. In assessing how health care costs might escalate in the future, it is useful to see how much they have risen in the past. In nominal terms, as the White Paper shows, expenditure on public health care has gone up by roughly 45% over the past five years or by 9% a year on average. Spending on private health care has gone up by very much the same proportion over the same period.

Let us assume that the NHI is introduced in full in the current financial year, at a conservative cost of R372bn – this being the combined total (in keeping with the pooling principle) of projected public and private health expenditure for this year. From such a base, NHI costs are likely to rise by 45% to R539bn in 2021, by a further 45% to R782bn in 2026, and then by a further 45% to R1 134bn in 2031.

Let us take the middle number (R782bn in 2026) and further assume that the economy will grow by 1.5% of GDP a year between now and then. On this basis, GDP in 2026 would amount to some R4 630bn. Expenditure on the NHI would thus constitute roughly 17% of GDP. Any such proportion is simply unaffordable.

What these projections show is that the NHI will always be chronically under-funded, with the extent of under-funding increasing as time goes by and health care costs rise further. This is what has happened in other countries too, where the National Health Service in the United Kingdom, for instance, confronts a major funding deficit. In practice – far from having quality health services made readily available to them via

the NHI – South Africans will find themselves waiting longer and longer for medical treatment as costs rise and the supply of health services diminishes.

### *Other economic variables*

Other economic variables are important too. These range from the value of the rand to interest rates, the growing burden of public debt, and the increasing likelihood that South Africa will have its sovereign credit ratings downgraded by more than one international ratings agency.

On current trends, the value of the rand is likely to deteriorate in response to perceived political instability and a largely stagnant economy. Inflation will then go up, putting pressure on the South African Reserve Bank to raise interest rates. Yet public debt already stands at some R2 trillion, having more than doubled since 2009 when it totalled R804bn. Already, the interest on this public debt costs the government a daunting R540m every working day. The interest burden will grow greater still if the country is indeed downgraded to sub-investment or 'junk' status – a consequence which the adoption of the costly NHI system could help to trigger.

The country's economic indicators are also deteriorating, rather than improving, as the mini budget in October 2016 shows. According to this Medium Term Budget Policy Statement, finance minister Pravin Gordhan expects a R23bn shortfall in revenue collections in 2016/17, compared to those earlier anticipated. With the economic growth rate for the year unlikely to exceed 0.5% of GDP, the budget deficit will also prove more difficult to tame and is likely to come in at 3.4% of GDP, a higher ratio than earlier expected.

Mr Gordhan has also flagged the need to bring in R43bn from additional taxes over the next two years to help the government finance its existing commitments. He has further stressed the need to trim current state expenditure by R26bn over the same period. He plans to cut spending by reducing the public service and curtailing the public service wage bill. This, of course, will leave little room to appoint the hundreds of additional officials the NHI system is likely to require.

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Already thus the government needs to reduce consumption spending – rather than expand it in the way the NHI requires – if it is to avoid having its sovereign credit rating downgraded to junk status by two or more ratings agencies. It also faces mounting pressure to increase its expenditure in other spheres and particularly on the 'free' university education it has promised to the poor and the middle class. Unless the economy begins to grow very much faster, the government will increasingly battle to find the revenue to finance its existing obligations. In these circumstances, it simply cannot afford to take on the enormous costs sure to be involved in implementing the NHI.

## Ramifications of the NHI proposal

The NHI proposal will increase demand without expanding supply, and is deeply flawed. It will not resolve poor standards and mismanagement in public health care. It will, however, succeed in putting an end to South Africa's excellent system of private health care. The NHI idea is also not based on any genuine desire to improve health services for South Africans. The real reasons behind it lie rather in the ANC's ideological hostility to the private sector and its determination to shift the country towards a socialist and then communist future. Not surprisingly in these circumstances, the NHI is also inconsistent with core provisions of the Constitution.

### *No remedy for problems in public health care*

The White Paper barely acknowledges the many problems in the public health care system. It also lacks any realistic proposals to overcome the shortage of health care providers, improve the management of health

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

In 2011, when the green paper on the NHI came out, the *Financial Mail* warned that the NHI was likely to become 'another costly white elephant'. It added: 'We do not need a new health system. We already have an extensive state-funded network of clinics and hospitals, supported by medical schools that are generally world-class. The public system is, in principle, available to everybody, but it has a reputation for being so badly managed and poorly resourced that anyone who can afford to pay medical aid fees chooses to buy the private services that are available. It is the unemployed and the poor who have no choice but to use public facilities.

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

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

*'Instead of attending to these mundane basics, the government wants to add yet more layers of expensive – and inevitably inefficient – bureaucracy. The NHI sounds grand and visionary, but it is the health equivalent of the disastrous outcomes-based education system that ruined the future of tens of thousands of children before it was abandoned.'*

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

None of these salient criticisms has been addressed in the White Paper. In particular, the most pressing of all problems – how to fix the public health care system and ensure that it starts to provide value for money – remains entirely unresolved.

### *An end to private health care in South Africa*

The White Paper does not, of course, acknowledge that the proposed NHI will effectively put an end to private health care in the country. This will, however, be the inevitable result once medical schemes are confined to providing unaffordable 'complementary' cover and the government takes control of pricing, payment, treatment protocols, and every other aspect of health care.

Many private hospitals, health professionals, and medical schemes under-estimate the ramifications of the NHI. Like most journalists and other commentators, they fail to appreciate that a crucial aim of the new system is effectively to nationalise the country's world class system of private health care. This will have enormous impact for the many millions of South Africans, both black and white, who increasingly prefer to rely on private health care as the state system falters and fails.

Private hospitals will not overtly be seized by the government. Nor will they be directly expropriated and taken into the ownership of the state, for that would require the payment of compensation under the property clause (Section 25) in the Constitution.

Instead, an 'indirect' or 'regulatory' form of expropriation will be used. Private hospitals will still be owned by private health care companies. But these hospitals, along with the specialists (and other health professionals) working at them, will lose almost all of their operational autonomy.

Under the NHI, the fees due to hospitals for the health services they provide free of charge to patients will be decided by bureaucrats employed by the NHI Fund. The fees payable to the specialists at these hospitals will also be decided by these bureaucrats. (These fees, moreover, will be set at the same level as the fees payable to specialists in the public sector, which will make it difficult for private practitioners to cover their overhead costs.)

The medicines that may be prescribed to patients will likewise be decided by NHI officials, as will the prices to be paid for these drugs. What medical devices, medical technologies, consumables, and other goods and services may be used to treat the sick will also be decided by NHI officials, while state price controls will again apply.

Private hospital groups will still own their hospitals. However, they will lose most of the usual powers and benefits of ownership – including the capacity to run their operations at a profit – under the comprehensive controls to be imposed by the state.

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The imposition of these controls will amount to a regulatory expropriation. Yet no compensation will be payable for expropriation of this kind under the Expropriation Bill of 2015.

This Bill was adopted by Parliament in May 2016 and needs only Mr Zuma's assent to be enacted into law. However, so flawed was the procedure used in its adoption by the National Council of Provinces that Mr Zuma has questioned this process and delayed signing the Bill.

Particularly relevant in the NHI context is the meaning of 'expropriation', which the Bill defines as the compulsory 'acquisition' of property by the state. The private hospitals in our example will not have been 'acquired' by the state. Hence, no expropriation will have taken place (according to the Bill) and no compensation will be payable.

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

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

Important too are the long delays that are likely to arise before the NHI Fund pays the fees due to hospitals, specialists, GPs, and others for the health services they have already provided free of charge. If experience with the Compensation Fund is taken as a guide, delays of 70 days or more could be the norm. Payment delays of ten years or more could also be encountered . Few private hospitals or private practices are likely to survive these further economic blows.

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

This outcome is also in line with the ANC's long-standing ideological hostility to the private health sector and the profit motive behind it. The ruling party takes the view (as Dr Manto Tshabalala-Msimang, minister of health in both Mbeki administrations, once put it) that the private health care system is little more than 'a ravenous monster that preys on our people'. Dr Motsoaledi, who has held the health portfolio since 2009, also seems driven by an ideological fervour against the private health care sector, which he has repeatedly stigmatised as intent on profiteering and extortion.

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

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Also in 2011, the minister blamed the private sector for 'a predatory health care system where the sick and the vulnerable are the ones who get attacked.' In 2012, while acknowledging that public hospitals were in a parlous state, he added that a large part of the public sector's problems stemmed from 'rampant commercialisation in medicine'. This constantly led to ever-rising prices, which reduced the number of people able to afford private care and increased the burden on the public sector. He blamed rapid increases in private hospitals on the 'over-provision' of medical services, along with unethical practices such as overcharging for surgical supplies and materials. He also poured scorn on the suggestion that prices were rising because medical scheme members were getting older and needing more expensive treatment. Instead, as *Business Day* commented, he continued to claim that the main cause of soaring medical inflation was 'private-sector greed'. Since then he has continued to castigate the private system, recently describing the mere 'existence' of medical schemes 'as a punishment for poor people'.

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

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

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

- dislodging business from a key sphere of market-based provision;
- giving the state control of all private health care resources, thereby effectively nationalising them;
- establishing the principle that private spending must be pooled with public revenues for the benefit of those in need,
- using the NHI precedent to extend this principle to other important areas, including pensions, where proposals for a government-controlled single pensions fund are now being taken forward; and
- consolidating mass dependency upon the government.

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

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

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### *Unconstitutionality of the NHI*

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

Proponents of the NHI say that the proposed system is essential to fulfil this right. But this is not so. Far from bringing about increased access to health care on a progressive basis, the NHI will deprive many South Africans of the access to health care that they currently enjoy. Introducing NHI is thus not a 'reasonable' measure for the state to take. It will also require a level of spending far in excess of the resources 'available' to the government.

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

The regulatory or indirect expropriation of all private hospitals, private practices, and private medical schemes is also contrary to the Constitution, irrespective of what the Expropriation Bill might say. Section 25 does not include a definition of 'expropriation' but the term is commonly understood as including both direct and indirect expropriation. This is also the meaning assigned to the term in a host of bilateral investment treaties around the world. In addition, if the state could simply circumvent the property clause by resorting to indirect expropriation, this would clearly (as the Constitutional Court has warned in a different context) undermine the careful balance that underpins the Constitution.

Fortunately, however, it is not necessary for the government to breach the Constitution in order to achieve universal health coverage and high standards of health care for all. These important goals can be achieved in other ways – and without what the minister himself describes as the 'drastic' and 'massive... alterations' that the NHI will require.

# PART 4: BETTER ALTERNATIVES TO THE NHI

**A new system of universal health care (UHC) must be practical and affordable. It should be based on market principles to promote competition and innovation, not leave South Africans dependent on an inefficient public sector monopoly. Everyone formally employed should have change-of-health-status insurance and belong to medical schemes (low-cost ones, where needed). These schemes should include individual health savings accounts (HSAs) to encourage both member prudence and provider innovation. Tax-funded health vouchers should be used to extend the same benefits to the jobless and the elderly. A culture of individual savings and self-reliance should also be encouraged, as in Singapore with its successful 'Medisave', 'Medishield' and 'Medifund' programmes.**

**The supply of health professionals and facilities must be expanded to match increasing demand for health services. Inefficiencies in the public health sector must also be overcome. This can partly be achieved via public-private partnerships, but it primarily requires a shift from damaging employment equity and BEE rules to a new system of 'economic empowerment for the disadvantaged' ('EED'). Whereas BEE helps only a small elite and harms the remainder, EED would quickly give the poor the benefits of much improved health care, education, and housing. It would also encourage investment, growth, and jobs – so expanding the wealth vital in promoting good health.**

## Basic principles

In devising better alternatives to the NHI, the first aim must be to introduce a system of universal health care (UHC) that is practical, financially sustainable, and in keeping with the recommendations of the World Health Organisation. Such a UHC system must aim to preserve South Africa's private health care system, while giving millions more people access to its benefits. A new UHC system must also aim to improve efficiency within the public health care sector, so as to ensure that the country gets much more bang for its already extensive health care buck.

> *A new UHC system must also avoid the effective nationalisation of private health care and be in keeping with the Constitution. It must aim to meet the health needs of all South Africans – not sacrifice these to the narrow ideological goals of a national democratic revolution (NDR) the majority of voters know little about and have never endorsed.*

In addition, a new UHC system must expand the supply of health professionals and health facilities. It must also use all its health resources in more innovative and effective ways. It should avoid replacing the rationing of health care by price with the rationing of health care by waiting time, as this is no advance at all. A new UHC system must also avoid the effective nationalisation of private health care and be in keeping with the Constitution. Above all, a new UHC system must aim to meet the health needs of all South Africans – not sacrifice these to the narrow ideological goals of a national democratic revolution (NDR) the majority of voters know little about and have never endorsed.

Important lessons can also be learnt from other countries – particularly the United States (US), which is

still grappling to introduce an affordable UHC system – and Singapore, which has succeeded in achieving this in a practical way. A full analysis of health challenges and achievements in either of these countries lies beyond the scope of this study. But many of the mistakes the US has made are evident in South Africa as well, while the essence of Singapore's approach can be identified and adapted for conditions here.

Many of the lessons to be learnt from the US come from the writings of health expert John C Goodman, a Senior Fellow at the Independent Institute, a policy think tank based in California. In seeking to reform health care, writes Dr Goodman, it is important to give the poor the same options as the middle class; to acknowledge that price controls can merely shift costs, not reduce them; and to recognise and remove the perverse incentives that current medical scheme policies have generated. It is also important to jettison the false belief that 'free' health services will create equality, when in fact they simply shift the basis on which health services are rationed from price to waiting time. This substitution brings little benefit to the poor or anyone else.

As Dr Goodman stresses, health care reforms should seek to give the poor the same options as everyone else. Often the poor are expected to rely on government to supply their needs, even as the middle class have 'access to the benefits of capitalism'. Such an approach is harmful to the disadvantaged, for it means that 'the middle class gets the benefits of competition' whereas 'the poor are left with public sector monopoly'.

> *'One of the most persistent myths is the idea that making health care free at the point of delivery will (a) create genuine equality of access to care and (b) be especially beneficial to low-income and disadvantaged groups'.*

Dr Goodman also cautions against the conviction that price controls on doctors and medicines are effective in reducing health care costs. What price controls do, he points out, is simply 'to shift costs from buyers to providers, rather than introduce any real efficiencies into the system'. It is also mistaken to assume that officials intent on stepping up state controls will be able to achieve the necessary efficiencies. Increased efficiency comes from imaginative new approaches and fresh ideas: from people who challenge conventional thinking, not from bureaucrats whose job is to enforce it.

As Dr Goodman adds, one of the major unacknowledged problems in the US (and also in South Africa) is that many of the rules governing medical schemes have served to distort or suppress market forces in this sphere. As a result, 'we are caught up in a dysfunctional system in which perverse economic incentives cause all of us to do things that raise the cost of care, lower its quality, and make access to care more difficult.'

For medical scheme members, artificially high contributions, combined with limited co-payments, create perverse incentives to consume as many health services as possible, even if these have little proven medical benefits (many diagnostic tests fall within this category). At the same time, many doctors – often paid fixed fees for every service rendered – have a perverse incentive to over-provide. In addition, medical schemes, which are compelled to take in the old and ill on the same terms as the young and healthy, have perverse incentives to under-provide to the former (so as to discourage them from joining) and to over-provide to the latter (so as to keep them within the fold).

Further bedevilling policy reform, he adds, is 'one of the most persistent myths' in the health care sphere. 'This is the idea that making health care free at the point of delivery will (a) create genuine equality of access to care and (b) be especially beneficial to low-income and disadvantaged groups'. This false claim is continually put forward, even though study after study has shown it to be flawed. In the United Kingdom, for instance, hospitals in wealthy areas are better resourced and offer a higher quality of care than their counterparts in poorer areas. In Canada, the wealthy and politically well-connected are often able to jump the long queues for specialist appointments and treatment, whereas the poor must simply wait (see *Part 3*).

In addition, long waiting times for health care cannot be avoided or reduced simply by the state's diktat. Once people have the promise of free health care, they will invariably demand very much more of it. Says Dr Goodman: 'Economic studies show that they will try to double their consumption of medical care.' If the supply of medical treatment cannot be increased in equal measure, the inevitable result will be long waiting times for everyone – and especially for the poor and disadvantaged.

A new UHC system for South Africa must bear these basic principles in mind. It must also seek to:

- increase access to private health care for all in formal employment;
- overcome the inefficiencies in the public health care sector;
- increase the supply of health professionals and health facilities;
- use a state-funded voucher system to provide access to medical schemes and health insurance for the unemployed and elderly;
- encourage individual savings and self-reliance, as in Singapore;
- be accompanied by a shift from BEE to 'economic empowerment for the disadvantaged' or 'EED';
- foster the medical innovation for which South Africa has long been renowned; and
- recognise the wider factors needed for better health outcomes, including increased investment, growth, and jobs.

## Increase access to private health care for the formally employed

To increase access to private health care for the formally employed, South Africa needs to remove perverse incentives among medical schemes and their members; increase individual choice and control over small-scale discretionary health spending; encourage provider innovations through the use of health savings accounts; introduce low-cost medical schemes for the poorly paid; protect people against adverse changes in their health status; and encourage employees to save for their future health needs.

> *'Once the money is in the pool, it is no longer "ours". When we draw from the pool, we are spending everybody's money.' Most people are more careful about husbanding their own resources than about conserving what they see as belonging to a wider group.*

### *Remove perverse incentives among medical schemes and their members*

Under government regulation, as outlined in *Part 1*, all South African medical schemes are required to apply open enrolment and community rating. They must simultaneously provide cover for some 300 prescribed minimum benefits (PMBs), and maintain capital reserves at 25% of all contributions received. These regulatory obligations have greatly pushed up the costs of medical schemes. They also mean that the great majority of members are paying monthly contributions that exceed both the actuarial risk they pose to the scheme and their own health needs. This gives members who are young and healthy a perverse incentive to over-consume health services until what they receive seems to them to match the contributions they are paying.

This perverse incentive is strengthened in two ways. First, medical schemes generally offer 'use-it-or-lose it' benefits, so members do not have the option of buying less health care and more of something else. Second, once a member pays a medical scheme contribution, that money is combined with the contributions that every other medical scheme member has made. As Dr Goodman writes: 'Once the money is in the pool, it is no longer "ours". When we draw from the pool, we are spending everybody's money.' Most people are more careful about husbanding their own resources than they are about conserving what they see as belonging to a wider group.

Because people have the right to join medical schemes at any time, they also have a perverse incentive to delay joining, preferring to 'jump in' only when they become ill or anticipate a costly health event, such

as the birth of a baby. Once they have received the medical treatment they need, they have a perverse incentive to exit the scheme again, so as to save on its excessive costs. As Dr Goodman writes, in the US 'people who game the system in this way are called "jumpers" and "dumpers"'.

At the same time, medical schemes have perverse incentives to over-provide to the young and healthy and to under-provide to the old and ill. If they do not succeed in these two objectives, they face the prospect of a 'death spiral' which will push them into bankruptcy. A death spiral occurs when more and more young and healthy people exit from a medical scheme, so that increasingly it is only the old and ill that remain. The costs of providing health care to these needy individuals will then rise to the point where they can no longer afford their monthly contributions and the medical scheme can no longer survive. In Dr Goodman's words: 'One reason for a death spiral is government price fixing, usually in the form of community rating and guaranteed issue [open enrolment]... Healthy people leave the pool because they are being overcharged. Sick people remain because they are being undercharged. This would not occur if each enrollee were charged a premium that reflects his or her actuarial risk.'

The easiest way to over-provide to the young and healthy, as Dr Goodman points out, is to 'offer services that healthy people consume: preventive care, wellness programmes, free check-ups, etc'. This tendency will be strengthened by the NHI, which is likely (as the White Paper indicates) to put great emphasis on preventive care at the primary level. This is also what has happened in the US under the Affordable Care Act, commonly known as Obamacare, which requires all medical schemes to cover 15 preventive services free of charge. These preventive services include mammograms, pap smears, and colonoscopies.

*Medical schemes have perverse incentives to over-provide to the young and healthy and to under-provide to the old and ill. If they do not succeed in these two objectives, they face the prospect of a 'death spiral' which will push them into bankruptcy.*

This regulatory intervention is based on the belief that preventive care pays for itself by catching diseases at early stages and so reducing treatment costs. For the few patients with diseases that are successfully identified via screenings, these preventive measures are indeed worth the expense. However, the extra costs of screening thousands of healthy people to find one patient with a problem usually swamps any savings that are achieved on patients whose diseases are diagnosed early. There are some exceptions to this general rule – childhood immunisations, for example – but these exceptions are few and far between.

Medical schemes are nevertheless happy to provide such screenings, as the relevant tests are relatively cheap and seem to offer something of value to the young and healthy. Yet if the majority of medical scheme members keep over-consuming health care that has little practical value – as if it were indeed 'free' – then society as a whole must ultimately pay a high price for this through increased contributions and additional taxes.

At the same time, medical schemes have a strong incentive to under-provide to the old and ill, and can achieve this goal in various ways. Writes Dr Goodman: 'The way to under-provide to the sick is to strictly follow evidence-based protocols and to be slow to approve expensive new drugs and therapies. Beyond that, a health plan can under-provide to the sick and discourage their enrolment by not including the best cardiologists and the best heart treatment centres in their networks.'

These perverse incentives should be ended by rolling back the regulations which have prompted them. South African medical schemes should once again be allowed to apply actuarial risk ratings in setting the monthly contributions of their members. This, together with the repeal of open enrolment rules, will encourage millions more people to join medical schemes when they are young and healthy. This will greatly help schemes to maintain their solvency without having to comply with the arbitrary 25% reserve requirement, which should be significantly reduced.

The contributions made by many thousands of young and healthy members would then help to cross-

subsidise treatment for the old and ill, who would also be expected to pay a risk-related contribution when they join (see below). To hold down costs still further, schemes should no longer be obliged to cover all PMBs. Nor should they be required, in the absence of relevant risk indicators, to provide all members with regular preventive screenings in the form of mammograms, pap smears, colonoscopies, and the like. Members paying risk-related contributions would then no longer have incentives to over-consume, while their medical schemes would no longer have reasons to over-provide to them.

People who are old and ill when they first join a medical scheme must also pay contributions based on their actuarial risk, which will thus be high enough to cover the cost of the treatment they require. However, people who join when they are young and healthy should not pay more than other members if their health status should later change. Rather, premiums should rise equally for everyone, while schemes should be protected from increased costs via the change-of-health-status insurance that all employees should be obliged to take out. Innovative ways will also have to be found to reduce the contributions of those who are already old and ill when they join medical schemes on a risk-rated basis (as further outlined in due course).

### *Increase individual choice and control over small-scale discretionary spending*

All medical schemes should incorporate 'health savings accounts' (HSAs) for all their members, from the young and healthy to the old and ill. HSAs allow people to put some of their monthly medical scheme contributions into a personal 'account' which they own and control. This gives them a choice as how the monies in their HSA should be spent. Ideally, individuals should be able to carry forward any unspent monies from one year to the next. When they retire or otherwise stop working, they should be able to access their accumulated HSA monies on a tax-free basis and use these for any purpose they think fit. This would put an end to the current 'use-it-or-lose it' problem and encourage people to be more prudent about their health care purchases.

> *'To the degree that people regard the money in HSA accounts as their own, they tend to be more careful, prudent shoppers when they enter the medical marketplace. To attract patients spending their "own" money, providers come under pressure to make prices transparent and to compete on price.'*

In the US, as Dr Goodman writes, some 30 million people now have HSAs included in their medical schemes. Studies have repeatedly shown that HSAs help to lower spending on medical treatment by some 30%, without jeopardising the quality of care that people receive. Says Dr Goodman: 'To the degree that people regard the money in HSA accounts as their own, they tend to be more careful, prudent shoppers when they enter the medical marketplace... In addition, to attract patients spending their "own" money, providers come under pressure to make prices transparent and to compete on price. Moreover, price competition normally leads to quality competition as well.' These factors have already had an enormous impact on the supply side of the market by encouraging a level of innovation among doctors and other providers that would otherwise not have been forthcoming.

With market principles restored through the repeal of adverse regulation, medical schemes would compete with one another to attract as many members as possible. One of the areas in which they could compete would be HSA design. As a governing principle, they should seek to follow the usual car or house insurance model, where people are content to pay for small discretionary sums out of their own pockets but want cover for big-ticket items where spending needs are major and unavoidable.

'The ideal medical scheme', writes Dr Goodman, 'would thus carve out whole categories of care which patients will pay entirely from their HSAs.' Included here would be almost all visits to GPs and other primary care, most diagnostic tests (in the absence of relevant risk indicators), most other out-patient care, and most acute prescription medicines. Different rules would generally apply to chronic medication, as described below.

For most in-patient treatments and procedures, medical schemes would negotiate with providers in their networks on standard fees for entire treatment regimens. Members would not be obliged to use these network providers, as this would constrain their choice. Instead, they would be free to go to alternative providers, who might charge more than this standard fee. However, members would then have to pay the difference out of their own pockets or from their HSAs. In this way, schemes would control their costs while members would still have a choice. That members could exercise choice in this way would also encourage schemes to maintain high standards within their preferred provider networks.

Members who have developed chronic conditions would have 'special care' HSAs, which would include not only their own HSA contributions but also the payments due to them under their change-of-health-status insurance policies. These members would then use their special care HSAs to manage and meet their health needs. Some commentators might object that the chronically ill cannot be trusted with this responsibility, but evidence from Germany, the Netherlands and the US shows that this is not so.

Writes Dr Goodman: 'Studies show that chronic patients can often manage their own care with results that are as good or better than traditional care. And if patients are going to manage their own care, it makes sense to allow them to manage the money that pays for that care... In Germany, long-term care patients who agree to manage their own budgets spend 50 percent less than what would have been spent in a normal plan. In the Netherlands, spending is 30 percent less.' Health outcomes are nevertheless generally better, for participants in these schemes tend to obtain more preventive care than others. These individuals thus have less need of costly crisis stabilisation and crisis support.

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Another useful precedent is to be found in the US, where Medicare (a federally-funded system of health cover for the elderly) now commonly includes 'cash and counselling' programmes. Notes Dr Goodman: 'Homebound, disabled patients manage their own budgets and hire and fire those who provide them with services. Satisfaction rates are in the mid-90 percentile (virtually unheard of in any health plan anywhere in the world).'

If the chronically ill were to manage their own HSAs, health providers would again have incentives to compete for their custom by increasing quality and reducing costs. Those with chronic conditions could then also benefit from the telephone consultations and other provider innovations that the introduction of HSAs has helped unleash.

In this situation, those with chronic conditions would no longer be unattractive to medical schemes in the way that they are now. On the contrary, these schemes would then have good reason to compete for the custom of the chronically ill. This competition is likely to unleash yet more innovation in the design of special care HSAs, thus bringing yet more help to those suffering from chronic illnesses.

### *Encourage provider innovations through the use of HSAs*

According to Dr Goodman, perhaps the greatest benefit from HSAs is to be found on 'the supply side of the health market'. When patients see themselves as spending their own money – and thus become more prudent and probing purchasers – health care providers come under pressure to compete for their custom on price, quality, and time.

Even before the introduction of HSAs, the salutary effect of provider competition was evident in the context of elective cosmetic surgery. Since such surgery is seldom covered by medical schemes, private providers are well aware that patients are paying out of their own resources and will be sensitive to price. Unlike

most other surgeons, those providing elective cosmetic surgery typically quote inclusive prices which cover all the goods and services required. This makes their prices transparent and easy to compare. The costs of elective cosmetic surgery have thus been falling in real terms, even as the costs of other types of surgery have been sharply rising.

A similar trend is evident as regards elective vision correction surgery, also not covered by most medical schemes. Laser eye surgeons must thus compete for customers not only on price but also on quality. Again, this has helped give impetus to various innovations. Advanced processes now offer more accurate correction, faster healing, and the capacity to treat a wider range of conditions. Again, competition has helped to keep prices down even as quality has improved.

In the US, the introduction of HSAs has encouraged competition and innovation in other aspects of health care too. Dr Goodman gives some examples:

*Laboratory and diagnostic testing:* Patients can now order their own blood tests without a doctor's appointment, and can compare the prices offered by different diagnostic testing facilities. Prices are 50% to 80% lower than for the identical tests performed in a hospital setting. These services lower not only money costs but also time costs, for test results are generally made available online within 24 to 48 hours.

*Price competition for drugs:* Walmart was the first nation-wide retailer to compete aggressively for the custom of those needing generic medicines. It did so by charging people a low uniform price for these medicines: $10 for a 90-day supply. In many cases, patients with medical scheme coverage found Walmart's prices lower than those at conventional pharmacies. Some pharmacy chains have now responded with their own pricing strategies.

*MinuteClinics and other walk-in clinics in shopping malls and pharmacies offer a range of primary care services. Their key advantage is that they lower costs in terms of both time and money. In addition, to ensure a consistent level of quality, nurse practitioners follow computerised protocols. Electronic medical records are thus used, while electronic subscriptions are the logical next step.*

*Price competition for drugs over the Internet:* Rx.com was the first mail-order pharmacy to make available the purchasing of medicines across the country. To compete with local pharmacies, it offers lower costs and a more convenient service, including free home delivery. It also competes on quality, for high-volume mail-order pharmacies tend to have lower dispensing error rates than conventional ones. Other online mail-order pharmacies have also thrived by offering improved quality, lower cost, and greater convenience.

*Patient education for drugs as a product:* DestinationRx.com is a pharmacy benefits management company. In addition to operating an online mail-order medicine delivery service, it offers a website that helps patients identify low-cost therapeutic substitutes for the medicines they currently take. The firm is also partnering with a supermarket chain to install drug comparison kiosks in pharmacies within its stores.

*Retail clinics:* MinuteClinics and other walk-in clinics in shopping malls and pharmacies offer a range of primary care services. Their key advantage is that they lower costs in terms of both time and money. In addition, to ensure a consistent level of quality, nurse practitioners follow computerised protocols. Electronic medical records are thus used, while electronic subscriptions are the logical next step. At the same time, electronic prescribing allows the use of error-reducing software.

*Telephone-based practices:* As of April 2014, Teladoc had 7.5 million customers paying for telephone consultations: for having access to a doctor at any time of day from any location. Because each on-call physician needs access to patients' medical histories (and the treatment decisions of previous doctors), personal and portable electronic medical records are used. The physicians prescribe drugs electronically, which facilitates the use of safety-enhancing software that checks for likely harmful interactions.

*Concierge medical practices:* Some innovative physicians are re-bundling and re-pricing the medical ser-

vices they provide. For a fixed monthly fee, they offer patients same-day or next-day appointments. They also help to schedule diagnostic tests, secure appointments with specialists, and negotiate prices and fees. Many will meet their patients at an emergency room to help ensure them prompt service. Many also save patients time and money by providing telephone and email consultations and offering convenient web-based services.

These innovations have been prompted by competition among private providers for the monies that people control for themselves through their HSAs. They have come about because doctors and entrepreneurs are thinking 'out of the box' in trying to find quicker and more affordable solutions. They would never have been developed by bureaucrats seeking to enforce a rigid set of rules. They have also been far more effective at bringing down prices – through genuine efficiency gains – than price controls could ever have been.

Competition has also helped to improve quality and lower costs for expensive in-patient procedures, such as joint replacement operations. A medical scheme in California, for example, found that charges for hip and knee replacements in the state ranged from $15 000 to more than $110 000. Yet there were also 46 hospitals in the state that routinely charged $30 000 or less. The medical scheme created a network consisting of these 46 facilities. Members could still go to other hospitals, but they were told the medical scheme would pay no more than $30 000 for a joint replacement outside its network. Some members did choose to go elsewhere, but facilities outside the network soon came under increasing pressure to match the $30 000 fee.

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Writes Dr Goodman: 'The cost of these other hospitals was cut by one third in the first year and continued to head towards the average network price over the next two years. This is dramatic evidence that when patients are responsible for paying the marginal costs of their care, health care markets become competitive very quickly. Remember, the medical scheme was not bargaining with these out of network providers. The patients were. So consider this: who is more powerful at controlling health care costs? Huge third-party bureaucracies negotiating with providers? Or patients paying the marginal costs of their own care.'

There are other telling examples, as Dr Goodman points out, of hospitals that offer particularly good value on particular procedures. One such is the Johns Hopkins Breast Center in Baltimore, which has developed an extraordinarily efficient and cost-effective way of carrying out a mastectomy. Whereas such an operation normally takes about two hours, the center has devised a way of successfully carrying it out in less than an hour. It also uses a different anaesthetic which lasts a shorter time. This means that recovery is quicker and side effects are fewer. Patients have the option of spending the night in the hospital, but most prefer to go home. Writes Dr Goodman: 'They can do so because several days prior to surgery they go through a three-hour training session with their care partner (usually someone who lives at home with the patient). Such training is important, because patients need to be able to monitor their own progress and recognise signs of potential trouble. In addition, after surgery, a nurse visits the patients in their homes twice.'

### *Introduce low-cost medical schemes for the poorly paid*

What of South Africans in formal jobs who earn below the personal income tax threshold (currently, some R6 250 a month) and should not be spending more than 10% of their monthly income on medical scheme

membership? Here, the solution lies in the low-cost option which the Council for Medical Schemes proposed in 2015 – but then withdrew under pressure from the ANC, which feared it would undermine the case for the NHI (see *Part 1*).

This low-cost option should be made available to all with earnings below R6 250. It should also mirror the council's 2015 ideas. It would thus exclude cover for PMBs and require members to use public rather than private hospitals. However, it would also entitle them to a minimum package of primary services. This would include five consultations a year with a private (GP) or other primary health provider, access to a pre- and post-natal programme, screening tests (where clinically indicated), and the provision of chronic and acute medicines. Monthly premiums would range from R180 to R240 per adult member per month.

This option would make medical scheme coverage available to millions more people. At present, 8.8 million South Africans belong to medical schemes: 3.9 million of them as main working members, 2.4 million as working dependents, and the remaining 2.5 million as non-working dependents. With this low-income option in place, a further 9.5 million employed South Africans would have medical scheme membership, either as main members or as working dependents. The number of non-working dependents belonging to medical schemes would also rise by an estimated 3.8 million. The number of South Africans with medical scheme membership would thus rise from 8.8 million to 22 million. Members belonging to these low-cost schemes would still have to rely on public hospitals. However, since most of their primary health care needs would be met by the private sector, this would greatly alleviate the pressure on state facilities.

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### *Protect people from adverse changes in their health status*

People also need protection against the catastrophic health expenses that might arise from major changes in their health status. This should be achieved by using the 'casualty' model of insurance. Here, people pay risk-related premiums that are actuarially fair and are entitled to the payment of compensation if the risks against which they are insured in fact occur.

It is the casualty model that applies, for example, when people insure their houses against damage from storms or subsidence. If these individuals have their roofs damaged by hail, their insurance assessors will quantify the extent of their losses and their insurance companies will pay out to each of them the amounts needed to make good the damage they have suffered.

The casualty model would need to be modified to some extent in the health care context. Ideally, the young and healthy should join medical schemes (low-cost ones, if needs be) as soon as they enter the formal workforce. They would then pay risk-related contributions that would be easy to afford. At the same time, they should take out 'change-of-health-status' insurance, which would also be based on their actuarial risk and would likewise cost little. Premiums could be kept low as all formal employees, numbering some 15.8 million people, would have insurance of this kind. This would make for a very large pool, helping to spread the risks insured. Employers could also be asked to pay half these insurance premiums for the benefit of their employees, which would further enhance affordability for all.

If some of these individuals later develop conditions (cancer or HIV/AIDS, for example) for which they are insured, their likely treatment costs will be quantified and they will be entitled to the payment of appropriate compensation. This compensation will, however, be paid into their HSAs in instalments over time. Their monthly medical scheme contributions will thus remain largely unchanged, rising solely in line with the increases that apply to all other members too. Their increased treatment costs would nevertheless be

met, without damage to the sustainability of their medical schemes, from the insurance payments made into their HSAs.

If these individuals later wanted to shift from one medical scheme to another – an option which must be made available to encourage competition between medical schemes and avoid members being trapped within poorly performing schemes – the insurance compensation would instead be paid into their HSAs at their new medical schemes. This arrangement would make them just as attractive to any medical scheme they might want to join as younger and healthier entrants would be.

The insurance companies responsible for paying out compensation for insured risks would also remain sustainable. These companies would receive monthly premiums from millions of young and healthy employees, and would have to pay out compensation only to the relatively few who become chronically ill or needed increased health treatment as they age.

To reduce the risk of a 'free-rider' phenomenon, the government should find effective ways of discouraging the spread of HIV/AIDS, limiting the rise of non-communicable 'lifestyle' diseases, and reducing current high rates of violent crime and negligent driving. People whose lifestyle choices or criminal and/or reckless behaviour have contributed to adverse changes in their own health status – or in the health status of others – should receive the normal insurance compensation to fund their treatment needs. However, they should also be obliged to put in appropriate periods of community service and/or prison time to help recompense society for the harm they have caused.

> *Formal employees who are already elderly or ill when these health reforms take effect will have to pay higher risk-related premiums. Special solutions will have to be found to help those earning too little to afford their monthly insurance premiums.*

What of those formal employees who are already elderly or ill when these health reforms take effect? They will, of course, have to pay higher risk-related premiums for their insurance cover than the young and healthy would do. Special solutions will have to be found to help those earning too little to afford their monthly insurance premiums. One option would be for their employers to make up the difference between what they can afford and what they are required to pay, for which these firms should earn 'EED' points (as further described below). Relatives might also be able to fill the gap, as the insurance cover thus obtained would help reduce the medical bills they might otherwise be called upon to pay. Some insurance companies might be able to reduce the premiums they would normally charge on a risk-related basis, depending on the overall income they receive. (Again, those which help in this way would earn EED points in recognition of their societal contribution.) Other firms might be able to find innovative and commercially sustainable ways to help bridge the affordability gap. As a last resort, a tax-funded voucher would be required to make up the shortfall and make these insurance premiums affordable to all. This, however, would be a diminishing rather than expanding liability for the state, as the number of elderly and ill employees needing this kind of help would decrease over time.

All kinds of health insurance should be allowed. Change-of-health-status cover would be compulsory for people with formal jobs, but individuals should also be able to take out 'gap' cover if they so wish. Should they need hospital treatment, their gap insurance would kick in to cover, for example, the difference between what a specialist in their medical scheme network would charge and the fee their preferred specialist might require.

### *Encourage employees to save for their future health care needs*

Many Western democracies confront large unfunded liabilities for the mounting health care needs of their ageing populations. By comparison, South Africa has a very youthful population, with half of its people still under the age of 25. This provides an important window of opportunity for the ANC government to avoid the problems that other countries face.

This can be achieved by requiring all those in formal employment to save for their future health care needs. Normal HSAs offer one way of doing so, as unspent monies can be carried forward to help meet future health care needs. However, a dedicated funding vehicle would also be advisable. All medical scheme members should thus be obliged to have what Dr Goodman describes as Health Insurance Retirement Accounts (HIRAs), in addition to their HSAs. Each HIRA would be funded via mandatory contributions, which would initially be set at 4% of payroll, with 2% coming from employers and 2% from employees. All HIRA funds would be invested in conservative and diversified international portfolios. These would be administered by an appropriate number of private sector firms, each of which would be appointed through an open and competitive tender process.

## Overcoming the inefficiencies in the public health care sector

An effective system of UHC must be able to draw on South Africa's extensive, but now often failing, public health care system. The inefficiencies bedevilling public health care must thus be addressed.

Poor management of many public hospitals and clinics remains a key problem. It helps explain why public health care revenue, amounting to R183bn this financial year, is often so poorly used. It also helps explain why only 16% of the public facilities monitored by the OHSC in recent years (or 6%, on the most recent figures available) were found to comply with basic norms and standards. The remaining 84% (or 94%) fell down badly on such essentials as infection control, the availability of medicines, and a caring attitude among nurses and other staff.

> *Misguided ANC policies are the main reason for the poor management so often evident. A rigid application of racial targets under the Employment Equity Act of 1998 has seen many people appointed to senior positions in hospitals, clinics, and health departments without the necessary qualifications and experience.*

Misguided ANC policies are the main reason for the poor management so often evident. A rigid application of racial targets under the Employment Equity Act of 1998 has seen many people appointed to senior positions in hospitals, clinics, and health departments without the necessary qualifications and experience. Many have been appointed on the basis of a clause in the statute allowing the selection of people with no proven capacity but merely the potential to 'acquire the ability to do the job' in the future. As one analyst comments, this clause has become 'the favourite loophole behind which kin, friends, and comrades have been favoured over more competent applicants'.

Cadre deployment – the ANC's strategy of appointing its political loyalists to key posts so as to cement the ruling party's control over key 'levers of state power' – has further compounded the problem. In 2012 a report by the state-funded Human Sciences Research Council (HSRC) warned that the ANC's deployment strategy 'systematically places loyalty ahead of merit and even competence and is therefore a serious obstacle to an efficient public service'.

Some of the ANC's most senior leaders have at times also acknowledged the problems arising from cadre deployment. In 2012, for instance, ANC secretary general Gwede Mantashe warned against 'deploying inexperienced ANC cadres to bureaucratic posts commanding huge and complex budgets'. This, he said, is 'like taking a mouse from the bush and making it run a cheese factory'.

Cadre deployment also often undermines attempts to hold under-performing officials to account. As home affairs minister Malusi Gigaba put it in 2010: 'Some of the people deployed,,,are clearly incompetent to occupy their positions... But when they buckle and fail to perform...they become arrogant and bigheaded, [knowing] they will be shielded by those who deployed them.'

Cadre deployment adds to a lack of accountability that now pervades the government from top to bottom. It also contributes to the 'patronage politics' that were flagged by the Mapungubwe Institute for Strategic Reflection (Mistra) in 2013 as a widespread and 'toxic' challenge to public sector efficiency. 'Of-

ficials are simply not sanctioned for wrongdoing. It is as if malfeasance is condoned. [This] shows a failure of oversight or unwillingness to hold wrongdoers accountable, and institutional performance consequently suffers.'

Against this already damaging background, the Labour Relations Act (LRA) of 1995 further undermines accountability by making it difficult to dismiss officials and managers who under-perform. Under the statute, dismissals are automatically unfair unless the employer can prove that they were carried out for good reason and following a fair procedure. The LRA also makes it easy and cheap for employees – whose dismissals may in fact be merited – to claim reinstatement or substantial damages before the Commission for Conciliation, Mediation, and Arbitration (CCMA). This in turn makes it difficult to dismiss poorly performing managers, many of whom should never have been appointed to the posts they hold.

This has particular salience for the many public hospitals which 'teachers, nurses, and even clerks' with no more than a matric have been appointed to run, as the Development Bank of Southern Africa reported in 2011 (see *Part 1*). Dr Motsoaledi expressed dismay at this finding, adding that unqualified chief executives had been appointed through 'a combination of bad policy and political patronage'. But he also stressed that ridding the system of these managers would not be easy and could certainly not be attempted 'en masse'. Though the minister did not refer to this, the LRA is a key reason why the unqualified cannot be dismissed and the experienced appointed in their place.

Preferential procurement under black economic empowerment (BEE) rules also harms the public sector by allowing wasteful spending and often encouraging corruption. Under the Preferential Procurement Policy Framework Act of 2000 (the Act), a 90:10 formula applies to tenders worth more than a specified threshold: currently R1m, but soon to be raised, by a staggering 9 900%, to R100m. According to this formula, 90 points are allocated on price and 10 points for the BEE status of the tendering firm. This means that BEE firms can charge 10% more than others and still be awarded a contract. Under the current rules, a 80:20 formula applies to contracts below the specified threshold, so allowing BEE firms to charge 20% more and still win the tender. However, these authorised BEE weightings – of either 10% or 20% – have often failed to prevent much higher price escalations.

*Authorised BEE weightings – of either 10% or 20% – have often failed to prevent much higher price escalations. Finance minister Pravin Gordhan lamented this in 2009, when he said that the government was paying 'R40 million for a school that should have cost R15m, R26 for a loaf of bread that should have cost R7.'*

BEE preferential procurement in state tenders has thus often made for enormous wastefulness. Finance minister Pravin Gordhan lamented this in 2009, when he said that the government was paying more for everything, from pencils to building materials, than a private business would: 'R40 million for a school that should have cost R15m, R26 for a loaf of bread that should have cost R7.'

In 2012 Mr Mantashe voiced a similar concern, saying that BEE companies must 'stop using the state as their cash cow by providing poor quality goods at inflated prices'. He also criticised officials for 'prioritising the enrichment of BEE companies through public contracts at the expense of…quality services at affordable prices'. Later that year, Mr Mantashe warned that the state would be ill advised to continue putting preferential procurement before service delivery. Said the ANC secretary general: 'This thing of having a bottle of water that you can get for R7 procured by the government for R27 because you want to create a middle-class person who must have a business is not on. It must stop.'

BEE procurement also contributes to corruption, which in turn makes inflated prices hard to avoid. Said a BEE businessman (who spoke to *The Star* newspaper in 2012): 'You pay to be introduced to the political principals, you pay to get a tender, you pay to be paid [for completed work], and you must also "grease the machinery". From time to time, you are called to make donations to....the ANC. There are also donations to

the youth league, the women's league and the SACP.' Those who failed to make the necessary payments either in cash or 'in kind' – by giving sub-contracts to the relatives of public servants and politicians – would find themselves excluded from state contracts worth many billions of rands.

Few other businessmen have admitted to making payments of this kind, but the comment is consistent with what both the finance minister and Mr Mantashe have said. It also provides insight into a wider pattern of fraud and inflated pricing, which has already reached crisis proportions. As Kenneth Brown, chief of procurement at the National Treasury, has recently warned, some 40% of the government's R600bn procurement budget is now compromised in this way.

The public health sector is not immune to these problems in BEE procurement. This is a key part of the reason why (as outlined in *Part 1*) a study carried out by the School of Public Health at the University of the Witwatersrand reported in June 2015 that the public health care system was 'sick with corruption and haemorrhaging money in irregular spending'.

If public health care is to become more efficient, the policies that currently erode its capacity must fundamentally be reformed. Employment equity, cadre deployment, and BEE rules should thus be replaced by a new system of 'economic empowerment for the disadvantaged' or EED, as further described below. Efficiency and accountability must be restored by appointing people with the necessary experience to run public hospitals and health departments. These individuals – not an outside agency such as the OHSC – must also be given the hard daily task of enforcing standards and maintaining discipline.

With these reforms in place, rapid progress could be made in enhancing performance and ensuring that all public health facilities comply with essential norms and standards. Pending the effective implementation of such reforms, the administration of public hospitals and clinics, along with the support functions of health departments, should be outsourced to private firms through an open and competitive tendering process.

*Employment equity, cadre deployment, and BEE rules should be replaced by a new system of 'economic empowerment for the disadvantaged' or EED. Efficiency and accountability must be restored by appointing people with the necessary experience to run public hospitals and health departments.*

In the words of Morgan Chetty, chairman of the Independent Practitioners' Association Foundation (an organisation representing doctors), 'the government seems to see the private sector as a threat', but in fact it offers the best way of turning the struggling public system around. Says Dr Chetty: 'Public-private partnerships have the potential to combine the best attributes of both sectors.' Under such a system, the government would be responsible for setting appropriate parameters, while the private sector would be responsible for effective and cost-efficient delivery. 'Ideologists think government has all the solutions and should implement the NHI. But pragmatists see a public-private solution.'

## Increasing the supply of health professionals and health facilities

Since a new system of UHC will greatly increase the demand for medical treatment, effective steps must be taken to increase the supply of both health professionals and health facilities. If this is not done, the UHC system will simply add to anger and frustration by raising expectations which then cannot be met.

The government should remove the regulations which currently prevent the private sector from providing training for doctors and specialists. If such training were permitted, private institutions could play a major part in increasing the supply of these professionals. South Africa's private hospitals are centres of excellence which are world-renowned for their high levels of care. Hence, privately-run medical training centres for doctors and specialists, working in conjunction with the best of these private hospitals, could attract internationally recognised teaching staff and provide a quality of training high enough to attract significant numbers of both local and international students.

As regards the training of nurses, the government should act on its long-standing pledge to re-open the

nursing colleges it closed in the late 1990s. It should also encourage private firms to establish many more training facilities for nurses. These should provide training at varying levels and also in vital specialist areas, including intensive care.

State-funded training vouchers should be made available to help people train as nurses, doctors, and specialists at both state and private training institutions. This should be done as part of the shift from BEE to EED. Business could be asked to contribute to the value of these vouchers, and would earn EED points for doing so. Graduates might also be expected to repay, say, 50% of the value of what the state has contributed to their training vouchers over time.

New approaches should also be used to expand the reach of doctors, nurses, and other health professionals. Consultations via telephone, e-mail, and Skype, facilitated by faster broadband and electronic patient records, should be encouraged. Trained nursing staff, with back-up support from doctors, should be allowed to consult and provide basic treatment, as many in the US now do via 'walk-in' clinics. Experienced midwives should be used to handle the bulk of straightforward births, with the support of doctors and gynaecologists wherever necessary.

Nursing staff could also be used, as at the Johns Hopkins Breast Center, to help train patients and their relatives on the danger signals to look out for after major surgery, so that patients can safely be sent home quickly and beds freed up. Nurses can also be used, again on the Johns Hopkins model, to visit patients at home after their discharge and check on the progress they are making.

> *The government should also encourage the establishment of more private hospitals and clinics. It should particularly promote the establishment of many more day hospitals, where numerous procedures can be carried out at lower cost.*

The government should also encourage the establishment of more private hospitals and clinics. It should particularly promote the establishment of many more day hospitals, where numerous procedures can be carried out at lower cost. In the US, some 63.5% of all surgical procedures are now carried out at such hospitals, but South Africa as yet has only around 50 of these institutions, while each new one requires express government approval.

Once regulatory constraints on new health facilities and the training and use of health professionals are removed, entrepreneurs and others will find countless other ways in which South Africa's health care resources could be expanded and put to even better use. The provider innovations that have already emerged in the US (as earlier described) should clearly be implemented here. The creative thinking evident in these new approaches is important in itself and, if fostered, is likely to spark many more sound ideas on how the supply of health services can be expanded to match accelerating demand.

## State-funded health vouchers for the unemployed and economically inactive

On the basis of the reforms earlier outlined, some 22 million South Africans with formal jobs, along with their non-working dependents, would be able to join affordable medical schemes and take out low-cost change-of-health-status insurance. But what of the many millions who are unemployed? Or the people who are too old or too young to participate in the labour market? They cannot be left out of a new system of universal health care. They must also be given the opportunity to take part in the same system as everyone else – not be hived off into a separate system that might well be inferior.

This objective can be achieved by introducing state-funded health vouchers for the 8 million South Africans who are currently unemployed on the expanded definition (which includes those not actively seeking work). Such vouchers should also go to the 4.3 million people who currently receive the state's old-age pension or disability grants. Children under the age of 18 would generally be included in the UHC system via their parents and the medical schemes to which they belong. (However, special provision would need to be made for double-AIDS orphans and those living in child-headed households.)

These state-funded health vouchers could be used solely to buy medical scheme membership and change-of-health-status insurance. With their help, recipients would be able to join low-cost medical schemes, at monthly contributions ranging (like those available to the formally employed) from R180 to R240 per adult member per month. These members would likewise have to use state hospitals, but they would also be entitled to minimum package of primary health services. This would include five consultations a year with a private (GP) or other private health care provider, along with various other benefits, as earlier described.

These health vouchers would also allow recipients to buy change-of-health-status insurance at low monthly premiums. Again, the compensation due when insured risks come to pass would be paid into the HSAs of the relevant individuals, helping them to pay for the increased medical treatment now required. Higher risk-related premiums would be payable by the aged, the disabled, and the chronically ill – and these could be funded in various ways. In the final resort, these higher premiums could be met through the state's topping-up of the usual voucher amount. (Again, this increased state liability would be a diminishing one, as more and more people would in time have had the opportunity to purchase change-of-health-status insurance when they were young and healthy.)

Health vouchers could be funded in three key ways. First, current tax credits for medical scheme contributions should be scrapped, which would add roughly R20bn to the personal income tax collected by the South African Revenue Service (SARS). Second, the Treasury should take advantage of the increased efficiencies that a shift from BEE to EED, coupled with the use of public-private sector partnerships, would bring to the running of public health facilities. Moreover, with R240bn a year currently compromised by fraud and inflated prices, the scope for savings is vast.

*With state-funded vouchers, recipients would be able to join low-cost medical schemes, at monthly contributions ranging from R180 to R240 per adult member per month. These health vouchers would also allow recipients to buy change-of-health-status insurance at low monthly premiums.*

Third, once low-cost medical schemes have been introduced, the number of people with medical scheme membership would rise from 8.8 million (as now) to some 39 million (22 million on the basis of formal employment and another 17 million via the voucher scheme, including each time the likely number of their dependents). With all these individuals meeting the bulk of their primary health care needs from the private sector, the demand on the public health system would decrease dramatically. This would greatly reduce the funding need at the national and provincial levels, allowing the Treasury to redirect the necessary revenue to the health voucher programme.

South Africa might also follow Sweden's example in privatising some of its key urban public hospitals and using the proceeds to fund health vouchers. In 1999, for instance, Stockholm's Health Services Council sold St Göran's, one of Sweden's largest hospitals, to a private company. A study of the privatisation programme found, among other things, that the hospital's costs for laboratory and X-ray services fell by 50% and overall costs by 30%. It also found (as Dr Goodman records) that 'on average, St Göran's now treats 100 000 more patients a year than it did as a public hospital, while using fewer resources'.

## A South African variant on the Singaporean system

Singapore is a tiny (622 sq km) island city-state at the tip of the Malaysian peninsula. It has four official languages (Chinese, English, Malay, and Tamal), reflecting the diversity of its population. It came to independence in 1965, when it was ejected from the Federation of Malaysia. Though it has very little land and no mineral or oil resources on which to rely, in 50 years it has grown into one of the wealthiest countries in the world, with average GDP per capita standing at some $52 900 in 2015. Its unemployment rate is 2.1% and its education system persistently ranks as the best around the globe. South Africa, by contrast, despite

having mineral resources of unprecedented value, had average GDP per capita of roughly $5 700 in 2015. Worse still, South Africa's unemployment rate now stands at 27% in general and at 54% among its youth, while its schooling system is one of the worst in the world.

Singapore also has a remarkably efficient health care system, rated 1st around the globe by Bloomberg in 2014. Its universal health coverage system is based on four core ideas: that people should take responsibility for their own health and avoid over-reliance on the state; that competition and market forces should be used to increase efficiency and reduce costs; that the government should intervene only where this is necessary to help the poor; and that no health care service should be free at the point of delivery, as this encourages over-consumption.

Universal health care in Singapore rests, in essence, on three programmes:

- the Medisave programme (created in 1984), which requires all employees to contribute between 6% and 9% of their earnings, depending on their age, into their personal savings funds to help fund medical treatment in both private and public hospitals. Medisave also provides for the delivery of a family's first three children and for expensive out-patient services, such as antiretroviral treatment;
- the Medishield programme (introduced in 1990 and since replaced by Medishield Life), a basic health insurance plan which helps pay for large hospital bills and various costly outpatient treatments, such as renal dialysis and chemotherapy for cancer; and
- the Medifund programme (created in 1993), an endowment fund, from which interest earned on the major capital sums invested by the government (standing at some S$1.39bn in 2010) is used to pay medical expenses which cannot be covered via the first two programmes.

*Universal health care in Singapore rests on three programmes: the Medisave programme, which requires all employees to contribute between 6% and 9% of their earnings into their personal savings funds; the Medishield programme, a basic health insurance plan; and the Medifund programme, used to pay medical expenses which cannot be covered via the first two programmes.*

This '3M' system, as it is widely known, has recently been supplemented by Eldershield, which provides insurance cover against severe disability for people aged 40 or more. In addition, the government subsidises up to 80% of total costs in acute public hospital wards, to which all Singaporeans have access. Tertiary care is provided predominantly in public hospitals, which make up some 80% of such facilities. The largest of these public hospitals have been organised as separate corporations, each with its own board of directors, so as to promote accountability and financial discipline and encourage entrepreneurial flexibility.

The primary sector is dominated by private sector providers, which account for some 80% of the market. In addition to maintaining their Medisave accounts, many Singaporeans belong to private medical schemes. Many also supplement their Medishield Life cover with additional private insurance cover. In the step-down care sector, comprising nursing homes, community hospitals, hospices and the like, services are generally provided by voluntary welfare organisations with the help of government subsidies.

Singapore has long had a culture of encouraging its people to save – not only for health care but also for retirement and other needs. The government-administered Central Provident Fund (CPR) was originally intended to compel citizens to save for their own retirement. With the passage of time, however, account holders have been given greater freedom to use their funds for a wider range of options, including purchasing homes, buying investments, and paying for university education. All savings, at both the time of deposit and the time of withdrawal, are tax exempt. Employees are expected to save 20% of their monthly salaries (up to a specified maximum), with a matching 20% coming from employers.

The alternative UHC system outlined here for South Africa is thus a variant on the Singaporean one, for

it includes individual HSAs, insurance against catastrophic health costs, government intervention to help those most in need, and measures to improve the efficiency of public provision. However, South Africa also needs to encourage a culture of savings, self reliance, and individual responsibility, rather than one of dependency upon the state. To facilitate this, it should copy Singapore's example in promoting growth, improving skills, and achieving full employment. In time, it should also seek to introduce a privately-administered but otherwise closer equivalent of Singapore's '3M' system, which has served that country very well in bringing universal health care to its population.

## A shift from BEE to EED

In 1994, shortly before it came to power, the ANC put forward a compelling case for affirmative action in employment and business. It did so, however, by holding out a beguiling vision of these policies, which in practice has proved flawed and false. Not surprisingly, the gains that were promised have thus not materialised. Instead, it is the ANC's own warnings about the potential damage from affirmative action that have proved prophetic.

In its 1994 document, the ANC said that affirmative action in employment would 'mainly' take the form of correcting past injustice through the application of 'normal and non-controversial principles of good government'. There would also have to be 'special measures' to bar racial discrimination, bring about 'balance in the armed forces, the police, and the civil service' and ensure that the workforce as a whole became 'representative of the talents and skills of the whole population'.

> *In practice, BEE has helped only a small and often politically connected elite. It has helped expand the black middle class, but it has also fostered a toxic mix of inefficiency, waste, and corruption that frequently causes great harm to 17 million poor black people heavily dependent on the state.*

These goals naturally garnered wide support across all racial groups. However, the vision thus held out has not in fact been realised under the Employment Equity Act. Instead, a rigid emphasis on racial 'targets' has undermined the efficiency of the public service, eroded the state's capacity for 'good government', and barred the use of many of the 'talents and skills' that would otherwise be available. In the public health care context, it has so undermined sound management that only 16% (or 6%) of health care facilities are able to comply with basic health norms and standards.

In its 1994 document, the ANC also said that BEE was needed to help remove 'all the obstacles to the development of black entrepreneurial capacity'. It would further help unleash 'the full potential of all South Africans to contribute to wealth creation'. Again, however, this is not what BEE policies have achieved in practice.

Instead, black entrepreneurship is being crippled (in the words of political analyst Moeletsi Mbeki) by BEE rules. These have 'generated an entitlement culture', in terms of which 'black people...think they should acquire assets free and that somebody else is there to make them rich, rather than that they should build enterprises from the ground'. In addition, far from contributing to wealth creation, BEE's major economic costs and ever shifting rules have also eroded business confidence, deterred investment, and helped reduce the economic growth rate to less than 1% of GDP a year.

In practice, BEE has also helped only a small and often politically connected elite, many of whom have used their political connections to garner great wealth through preferential procurement and/or ownership deals. Though BEE has thus helped to expand the black middle class, it has also fostered a toxic mix of inefficiency, waste, and corruption that frequently causes great harm to the 17 million poor black South Africans heavily dependent on the state for public hospitals and clinics, schools, houses, water, sanitation, and other services. At the same time, 85% of black South Africans have little prospect of ever themselves benefiting from the BEE procurement contracts, management posts, or ownership deals that have enriched the remaining 15%.

Efficient public health services will not be possible while employment equity and BEE rules continue to hobble hospital management, health departments, and health care procurement. These rules must thus be scrapped. At the same time, however, new policies must be implemented that will genuinely overcome past injustice and increase opportunities for the poor and disadvantaged. This cannot be achieved without overcoming the key barriers to upward mobility. These include meagre economic growth, one of the worst public education systems in the world, and stubbornly high unemployment rates, especially among the youth.

The solution thus lies in shifting away from employment equity and BEE and embracing a new system of 'economic empowerment for the disadvantaged' or 'EED'. EED focuses not on outputs in the form of numerical quotas, but rather on providing the inputs necessary to empower poor people. Far from overlooking the key barriers to upward mobility, EED seeks to overcome these by focusing on all the right 'Es'. In essence, it aims at rapid economic growth, excellent education, very much more employment, and the promotion of vibrant and successful entrepreneurship.

With BEE replaced by EED, the public sector can abandon its current misguided emphasis on racial targets in employment and procurement. Freed from these shackles, public hospitals, public clinics, and health departments at national, provincial, and municipal levels will begin to function far more effectively. This will give the country far more bang for its already extensive health care buck. Increased efficiency will also make it possible for public health facilities to start competing for the custom of millions of medical scheme members. This in turn will encourage private facilities to up their game still further, thereby adding to the range of high quality health services available to all South Africans.

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Under EED, business would contribute to empowerment (and earn voluntary EED points for so doing) primarily through the direct investments it makes, the jobs it maintains or creates, and the contributions it makes to tax revenues and export earnings. These are by far the most important contributions to upward mobility that business can make. Jobs and earnings are vital to individual dignity and self-reliance. They also offer people the surest and most sustainable path out of poverty. The tax revenue and/or export earnings that business generates are essential in meeting infrastructure, education, and other needs. Hence, it is only when business of every kind and every size – from the street vender to the major corporation – is able to thrive and expand that real opportunity can be generated and full employment achieved. Only in this context too, can a Singapore-type private savings scheme be effective in helping people to accumulate the funds they need, not only for health care, but also for housing, tertiary training, and a dignified retirement.

At the same time, the disadvantaged have immediate needs which business can also help to meet. They need quality and affordable health care. They need excellent education. They need proper housing and sound living conditions. At present, the government promises these benefits but often fails adequately to deliver. Some 4% of GDP is spent on public health care, but only 16% (or 6%) of public facilities comply with basic norms and standards. More than 6% of GDP is spent on education, but the schooling system remains one of the worst in the world. Some 3% of GDP goes to housing and community development, but more than 2.1 million households still remain on the national housing waiting list. It will also take at least 20 years, at the state's current rate of delivery, to clear the existing backlog, let alone meet new housing needs.

EED can help address these problems. Instead of making people wait on the state to deliver, individuals should be empowered to meet their own needs via state-funded vouchers for health care, education, and housing. These vouchers would help them buy what they require from private suppliers.

Business can also help improve the health care, education, and housing on offer in various innovative ways. In the health care context, for example, it could implement the various provider innovations already introduced in the US. In education, it could develop interactive on-line mathematics tutorials to help pupils test their knowledge and understand where their efforts have gone wrong. In the housing sphere, it could develop low-cost housing materials that would be readily available, easy to assemble, and environmentally sound.

With these three vital spheres opened up to private provision and entrepreneurial innovation through the voucher system, the range of improvements introduced could soon be dizzying. Business would earn EED point for all such contributions, while disadvantaged South Africans would benefit enormously.

Business could also contribute financially in various ways. In the health care context, for example, business could help lower paid employees by contributing more than the usual 50% to their medical scheme contributions and health insurance premiums. It could also assist by depositing additional funds into the HSA accounts of low-paid staff. It could top up the tax-funded health vouchers provided by the state to the unemployed and elderly, or make training vouchers available to those wanting to qualify as nurses and other health professionals. An endless array of innovations would be unleashed – all of which would directly help to empower the truly disadvantaged.

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## Encouraging more medical innovation

Health care needs can also be more effectively addressed by encouraging more medical innovation. South Africa already has a proud record here. The first ever heart transplant in the world was carried out in 1967 at Groote Schuur, a public hospital in Cape Town. South Africans have also been responsible for a number of vital medical inventions, including:

- the Computed Axial Tomography (CAT) scan, which uses an X-ray source and electronic detectors, as analysed by a computer, to produce a sharp map of the tissues within a cross-section of the body and so helps to detect disease;
- the 'power-free' foetal heart monitor, which uses ultra-sound to monitor a baby's heart rate during labour and relies on solar energy rather than mains electricity;
- the retinal Cryoprobe, a pencil-shaped device with a frozen tip which is important in cataract surgery and was used to treat British prime minister Margaret Thatcher in 1983 and President Nelson Mandela in 1994;
- the Smartlock safety syringe, which provides improved protection against needle-stick injury and contamination by hepatitis or HIV and has saved countless lives;
- the Lodox scanner, which provides full body X-ray images in just 13 seconds, with a minimal radiation dose and exceptional image quality, and is used in many hospital trauma units as it provides a quick and accurate full-body overview of injuries and foreign bodies; and
- the RoboBEAST, a 3-D printer for ordinary, non-technical people that enables them to print artificial Robohands of any size.

One of the key aims in any universal health care system must be to encourage further medical innovation. This can come only from a system that welcomes the participation of the private sector and encourages competition. A rigid bureaucratic NHI system aimed at effectively nationalising the private sector and

excluding entrepreneurs will stifle new ideas and leave no space for different ways of doing things. This in itself is reason enough to jettison the NHI proposal. By contrast, moving instead to the UHC system outlined here will help South Africa remain at the forefront of creative thinking in tackling the country's complex health challenges.

## Other factors are important too

As Dr Goodman writes, many of the people responsible for devising health policies seem to be 'obsessed' with the idea of increasing access to state-controlled health insurance. 'In fact,' he notes, 'they are more concerned with whether people are insured than whether they get health care.' This overlooks the reality that increasing demand for health services without increasing supply will simply lead to rationing by waiting time. It also ignores the fact that health outcomes depend only partially on medical treatment. Still more important, writes Dr Goodman, are 'other factors, including exercise, diet, sleep, smoking, pollution, climate, and social status'.

Particularly vital in South Africa is the need to stimulate growth and jobs, so that increasing numbers of people have rising incomes – and can afford more extensive medical scheme benefits. There is also a positive correlation between wealth and health that has consistently been demonstrated in countries around the globe.

World-wide, GDP has increased from some $12 300bn in 1970 to $36 200bn in 2005 (at constant 2000 prices). At the same time, life expectancy around the world has increased from an average of 58 years in 1970 to an average of 66 years in 2005. Comments Jasson Urbach of South Africa's Free Market Foundation: 'The correlation between wealth and health is by no means serendipitous – as nations become wealthier, more money becomes available for expenditure on health care.' Countries with higher GDP can also more easily afford piped water and modern sanitation, increased and more varied food supplies, and comprehensive immunisation programmes.

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The surest way to increase wealth and health in South Africa is not to nationalise the private health care section under the NHI proposal, but rather to roll back state intervention and allow more economic freedom. Economic freedom – which, in its true sense, means freedom from excessive state control over the economy – is vital to the prosperity of every nation. As data from all over the world has repeatedly shown, it is a crucial factor in achieving higher rates of economic growth, increasing GDP per capita, and extending average life expectancy.

The importance of economic freedom is particularly evident in a report published by the Fraser Institute, as part of its Economic Freedom of the World Index, which covers the period from 1990 to 2010. This report shows that GDP per head in the 'least free' countries grew at an annual average rate of 1.6% over this 20-year period. By contrast, GDP per head in the 'most free' countries grew by 3.6% on average, or more than double. Because of this difference in growth rates, the least free countries recorded average GDP per head of $5 200 in 2010, while the most free recorded close on $38 000 – almost seven times higher. Moreover, the average per capita income of the poorest 10% of people in the least free countries was $1 200, whereas in the most free it was nearly $12 000, or almost ten times as much. In addition, life expectancy was more than 20 years longer in the most free countries than it was in the least free ones.

If South Africa is to attain the benefits of economic freedom, the ANC's outdated and damaging NDR ideology must be jettisoned. So long as the ruling party remains intent on pursuing a socialist and communist future, investment will be muted, growth limited, and unemployment high. This dismal situation is also

precisely where South Africa now finds itself.

However, even in its current straitened circumstances, the country could still implement a universal health coverage system, of the kind outlined above, that would be practical, affordable, and effective. However, if this UHC system is to expand and improve the benefits it offers, unemployment must fall to 6% or less, the tax base must vastly expand, and the annual growth rate must rise to a minimum of 5% of GDP a year. All these gains can yet be achieved. However, they will become increasingly unattainable if the ANC continues to propel the country down the NDR path.

The proposed NHI system is itself a key vehicle for advancing the NDR. It will push the private sector out of a key sphere and could drive much of the skilled middle class out of the country. It doing so, it will further hobble the economy and vastly increase dependency upon the state. It will also turn access to health care into a potent additional political weapon in the hands of the ANC.

Better ways to achieve universal health care must thus be found. Better ways of doing so have been outlined here. South Africans need to understand the great threat that the NHI poses. They also need to mobilise to defeat this threat if they want to avoid losing many of the political and economic freedoms that the ending of apartheid finally brought within their grasp.