South African Institute of Race Relations NPC (IRR)
Submission to the
Select Committee on Health and Social Services,
National Council of Provinces,
regarding the
National Health Insurance Bill of 2019 [B11B – 2019]
Johannesburg, 15th September 2023

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Introduction

The Select Committee on Health and Social Services in the National Council of Provinces (the select committee) has invited interested persons to submit written comments on the National Health Insurance Bill of 2019 [B11B – 2019] (the NHI Bill) by 15th September 2023.

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

No proper public participation

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

The key constitutional provisions in this regard are Sections 59, 72, and 118. According to Section 72(1) of the Constitution, the National Council of Provinces (NCOP) 'must facilitate public involvement in the legislative…processes of the Council and its committees'. In the *New Clicks* case in the Constitutional Court, Mr Justice Albie Sachs noted that there were many ways in which public participation could be facilitated. He added: 'What matters is that…a reasonable opportunity is offered to members of the public and all interested parties *to know about the issues* and to have an adequate say'. This passage was quoted with approval in *Doctors for Life*, the *Land Access* case, and in the *Mogale* judgment striking down the Traditional and Khoi-San Leadership Act of 2019.[2]

Incomplete and partial information

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

a) what health services the proposed NHI Fund will initially cover, and how much this coverage will be reduced from year to year as budget constraints worsen;

[1] (CCT73/05A) [2006] ZACC 12; 2007 (1) BCLR 47 (CC); 2006 (6) SA 416 (CC); 2016]ZACC 22; [2023] ZACC 14

[2] Section 59(1), Constitution of the Republic of South Africa, 1996; *Minister for Health and another* v *New Clicks South Africa (Pty) Ltd and others*, [2005] ZACC 14, at para 630, emphasis supplied by the IRR; *Doctors for Life*, at para 145; *Land Access* judgment, at para 59; *Mogale* judgment, at para 34

b) how the supply of health professionals and facilities can realistically be expanded to cater for the increase in demand the promise of 'free' health services is sure to trigger;
c) just how big a bureaucracy will be needed to administer the NHI Fund and implement its proposed controls on every aspect of healthcare;
d) how the NHI Fund can realistically be shielded from the gross inefficiency and rampant corruption that increasingly plague the public service and other state entities;
e) what the NHI system is likely to cost, the 2010 estimate of R256bn in 2025 being thirteen years old and entirely unrealistic;
f) how the country can afford the large sums likely to be needed for the NHI when the economic growth rate is so low (a projected 0.4% in 2023) and the unemployment rate is so high (32.6%), and public debt will soon reach 74% of GDP;[3]
g) why warnings from the National Treasury and the Davis Tax Committee that the NHI is 'unaffordable' and 'unsustainable' are being ignored;
h) whether the increased taxes needed to fund the NHI can realistically be imposed on a small and already over-burdened tax base;
i) how much of the additional revenues raised, ostensibly for NHI purposes, will in fact be allocated to the NHI – and how much will instead be spent on bailouts for failing state-owned enterprises (SOEs) or other perceived needs; and
j) why medical schemes are in time to be confined to providing 'complementary' cover and so 'collapsed' into the NHI Fund – when the NHI will clearly not be able to meet the country's health needs and South Africans will still require an effective private sector alternative on which to rely.

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

Tainted public hearings

Initial public hearings on the NHI were profoundly tainted, including those held in Mpumalanga in 2019. Though these hearings were intended to gather the unvarnished views of ordinary South Africans, they were instead turned – in the graphic words of Siviwe Gwarube, then DA shadow minister of health – into a 'clash of the buses'. As Ms Gwarube has pointed out, 'the ANC packed the halls with party supporters – an act which was not only wrong but completely distorted the findings of the process'.[4]

[3] South African Reserve Bank (2023), Statement of the Monetary Policy Committee (July 2023), p. 2-3, https://www.resbank.co.za/content/dam/sarb/publications/statements/monetary-policy-statements/2023/july-/Statement%20of%20the%20Monetary%20Policy%20Committee%20July%202023.pdf; Stats SA. Quarterly Labour Force Survey (QLFS) Q2:2023; National Treasury (2023). Budget 2023 – Budget Review. https://www.treasury.gov.za/documents/national%20budget/2023/review/FullBR.pdf
[4] Siviwe Gwarube, 'Parliament again found wanting', *Daily Maverick* 31 October 2019

Sfiso Nkala of civil society organisation Section27, who attended the Ermelo event, commented that it was 'like an ANC rally, not a public hearing. About 90% of the people were wearing ANC regalia; you can't help thinking that these people came from the branches and from the ANC alliance partners'. Moreover, as people were queuing up for their turn to speak, they were told 'to have their say, but also to state that they endorsed the NHI' – a blatant manipulation of the process.[5]

A massive propaganda exercise in support of the Bill was also mounted. As the then chairperson of the portfolio committee on health, Dr Sibongiseni Dhlomo (now the deputy minister of health) told the media soon after the public hearings began, 'the Department of Health has released about a million pamphlets in all 11 languages for people to read about it… It has also been placing newspaper adverts. They have been in the media. They have been on radio.'[6]

The message conveyed was not that the NHI is 'unaffordable' and 'unsustainable' – as both the National Treasury and the Davis Tax Committee have warned – but rather that the new system would 'benefit and uplift the poor': that it would help 'the sick and the old like my grandmother, my grandfather, and the uncle of my father', as Dr Dhlomo put it.[7]

According to Dr Dhlomo, people were also told that the Bill was vital to 'social solidarity' and that all resources must be 'pulled together' if the needs of the poor were to be met. They were further asked if they were 'ready and available' for the 'young to carry the old', the 'healthy to carry the sick', and the 'wealthy to carry the poor'.

Those unable to speak at the public hearings were encouraged to write down messages in which they said, for example, 'I like the NHI because it has a capacity to assist my mother', or 'I don't like it because I do not think I'll benefit'. But they were also told that the only people opposed to the Bill were those who 'wanted to continue to benefit alone and not benefit the collective' – the ones who wanted to 'push aside other South Africans to make themselves benefit'.[8]

Dr Dhlomo nevertheless claimed that the processes being followed were fair, that the pamphlets being distributed were only 'one part of public engagement', and that all that he and his colleagues were doing at the public hearings was to 'listen to what people are saying so that we can collate that feedback' and take it back to Parliament. However, as Mr Nkala said of the Ermelo hearing, 'It was like they wanted to make sure that it looked like the NHI Bill had everyone's approval. It was just a sham'.[9]

[5] Ufriedo Ho, 'Questions raised over NHI public hearings', *Daily Maverick*, 10 November 2019
[6] Dr Sibongiseni Dhlomo calls on public to get involved, *Daily Maverick*, 30 October 2019
[7] Ibid
[8] Ibid
[9] Ufriedo Ho, 'Questions raised over NHI public hearings', *Daily Maverick*, 10 November 2019

These initial public hearings were conducted in all provinces from 26 October 2019 to 24 February 2020, after which the Covid-19 lockdown intervened. Some 960 oral statements were made at these hearings, roughly 85% of which supported the NHI Bill, while 12% opposed it and 2% raised issues unrelated to it.[10]

However, relatively few people participated in these hearings, according to Freedom Front Plus MP Philip van Staden. 'More people could have gone out to these public meetings if the advertisements for these meetings had been adequately advertised not only by Parliament but also by the provinces and local municipalities,' he says. This raises questions as to whether the requirements for proper public participation were adequately met.[11]

Parliament is required to be proactive in ensuring adequate participation, as the Constitutional Court has recently stressed in the *Mogale* case. Among other things, it must ensure that invitations are sent out well in advance of public hearings, that at least seven days' notice is given of each one, that transport is supplied where needed, and that people are provided with pre-hearing information that accurately describes a pending law without 'misrepresenting' its content or ramifications. People must also be given enough time and information for them to be able to provide 'meaningful input'. In addition, all those wanting to speak must be treated equally. Some groups must not be favoured over others – and no attempt must be made to silence any of those present.[12]

These requirements have not been met as regards the NHI Bill. Not enough notice of public hearings was given, while the information provided was partisan and partial at best. In addition, as Ms Gwarube warns, all the public hearings on the NHI Bill were 'deeply politicised and often did not provide an honest reflection to the people of South Africa about what the Bill seeks to do and how it will go about it'.[13]

In addition to the oral hearings, close on 339 000 written submissions were sent to the portfolio committee. Of these, said committee chair Dr Kenneth Jacobs, some 283 000 were 'accompanying submissions, including petitions supporting some of the submissions'. These 283 000 submissions may effectively have been ignored, even though the people submitting them saw them as reflecting their own views and wanted them to be taken into account.

If this approach was indeed adopted, then only around 56 000 written submissions would have been seen as meriting any further analysis. Worse still, this analysis was clearly

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[10] https://www.politicsweb.co.za/politics/na-passes-nhi-bill-and-land-court-bill--parliament; https://www.dailymaverick.co.za/article/2022-02-09-where-are-we-in-the-national-health-insurance-legislative-process-and-what-happens-next/

[11] https://www.dailymaverick.co.za/article/2022-02-09-where-are-we-in-the-national-health-insurance-legislative-process-and-what-happens-next/;

[12] Media Summary, *Mogale and others* v *Speaker of the National Assembly and others*, [2023] ZACC 14

[13] https://www.dailymaverick.co.za/article/2022-02-09-where-are-we-in-the-national-health-insurance-legislative-process-and-what-happens-next/

conducted in a partisan and truncated way. As Dr Jacobs has explained, 'All the shorter submissions (about one page) were captured into metadata, categorised, and thematically analysed into a report. Elaborate submissions ranging from 2 to 200 pages were analysed using an analytical tool that captured the name of the submitter and clause-specific comments with suggestions and recommendations thereof.'[14]

In other words, the committee chose to disregard the content of all the longer submissions, except insofar as these documents made 'clause-specific' comments on the Bill. Yet many of the most telling problems with the Bill are not reflected in its wording. They lie rather in the Bill's silence on a host of vital questions, as earlier outlined. These questions range from the benefits the NHI Fund will provide to the costs of supplying free health services to more than 60 million South Africans – and how these health services are to be financed and sustained when tax revenues are so limited and public debt already so high. As Dr Jacobs's own description makes clear, the evidence marshalled on these (and many other important questions) was excluded from proper consideration because it did not fit with the committee's narrow clause-specific approach.

Questions also remain as to how many of the people and organisations that sent in written submissions were invited to make oral presentations to the committee in support of their written documents. The general rule is that anyone who provides a written submission and asks to make an oral presentation should be given the chance to do so. Whether this was in fact done on the NHI Bill remains uncertain. All that is clear is that the number of oral presentations made to the committee between 18th May 2021 and 23rd February 2022 was small compared to the number of submissions sent in: 107, according to one report; 114, according to another report; and 135 according to a third.[15]

In addition, a parliamentary report on the outcomes of the public consultation process – and the comments made via public hearings, written submissions, and oral presentations – has yet to be released to the public. Though copies of this report are supposed to be available on written application to the secretary of the health portfolio committee,[16] this is a cumbersome process. In addition, based on the IRR's experience to date, the committee secretary will simply to ignore such applications.

Even the MPs serving on the health portfolio committee seem to have been confined to a 'high-level summary' of this parliamentary report. As *Business Day* records, opposition MPs were denied 'an opportunity to interrogate the material presented by the committee's content advisor, Ms Lindokuhle Ngomani'. In addition, when they questioned how the Bill could be

[14] https://www.dailymaverick.co.za/article/2022-02-09-where-are-we-in-the-national-health-insurance-legislative-process-and-what-happens-next/

[15] https://www.businesslive.co.za/bd/national/health/2022-11-17-state-will-press-ahead-with-nhi-regardless-of-state-of-economy-phaahla-says/; https://www.politicsweb.co.za/politics/na-passes-nhi-bill-and-land-court-bill--parliament; https://www.dailymaverick.co.za/article/2022-02-09-where-are-we-in-the-national-health-insurance-legislative-process-and-what-happens-next/

[16] Email to the IRR from Lindokuhle Ngomani, content adviser, Portfolio Committee on Health, 25 August 2023

taken further when so many key concerns had yet to be answered, this objection was simply dismissed. According to the ANC's Nhlanhla Xaba, no important issue had been overlooked. On the contrary, he claimed, the ANC had 'seriously analysed the submissions made by stakeholders and made changes, where necessary, clause-by-clause.'[17]

Again, however, this approach ignores the fact that many of the most serious problems with the Bill lie outside its wording. It also brushes aside the fact that some views – particularly those presented at oral hearings dominated by ANC supporters – were seemingly allowed to prevail over all the considered evidence assembled in at least 56 000 written submissions and more than a hundred oral presentations.

In addition, the government's own requirements for proper consultation – as set out in its own policy documents in 2015 and 2020 – were evidently disregarded.

Guidelines for the Socio-Economic Impact Assessment System, 2015

All new legislation in South Africa is supposed to be subjected to a comprehensive 'socio-economic impact assessment' before it is adopted. The relevant requirements are set out in *Guidelines for the Socio-Economic Impact Assessment System (SEIAS)*, which were developed by the Department of Planning, Monitoring, and Evaluation in May 2015 and took effect in September that year. The aim of the SEIA system is to ensure that 'the full costs of regulations and especially the impact on the economy' are fully understood before new rules are introduced.[18]

According to the *Guidelines*, the SEIA system must be applied at various stages in the policy process. Once new legislation has been proposed, 'an initial assessment' must be conducted to identify different 'options for addressing the problem' and making 'a rough evaluation' of their respective costs and benefits. Thereafter, 'appropriate consultation' is needed, along with 'a continual review of the impact assessment as the proposals evolve'.[19]

A 'final impact assessment' must then be developed that 'provides a detailed evaluation of the likely effects of the [proposed law] in terms of implementation and compliance costs as well as the anticipated outcome'. When a bill is published 'for public comment and consultation with stakeholders', this final assessment must be attached to it. In addition, a particularly important need is to 'identify when the burdens of change loom so large that they could lead to excessive costs to society, for instance through disinvestment by business or a loss of skills to emigration'.[20]

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[17] https://www.businesslive.co.za/bd/national/health/2022-11-22-health-committee-presses-for-nhi-bill-adoption-before-anc-conference/?ut

[18] Department of Planning, Monitoring and Evaluation, 'Socio-Economic Impact Assessment System (SEIAS), Revised Impact Assessment: National Health Insurance Bill', 26 June 2019 (2019 SEIAS Assessment); *SEIAS Guidelines*, p3, May 2015

[19] *SEIAS Guidelines* p7

[20] *SEIAS Guidelines*, p11

The NHI Bill is likely to trigger precisely such 'excessive costs', in the form of both disinvestment and emigration. Yet no proper SEIA assessment of the NHI Bill has been carried out. A supposed analysis of this kind was published in June 2019,[21] but this assessment is entirely inadequate and simply brushes over all the vital issues needing to be properly evaluated.

Far from providing a realistic assessment of the likely costs and benefits of the NHI system, the 2019 SEIA report simplistically echoes the government's optimistic assumptions about the benefits the NHI will bring. It presumes that these benefits will in fact be achieved, while failing to interrogate the likely costs of the NHI. It also ignores the vital question of whether South Africa can afford to introduce, or sustain the NHI, when economic growth has failed to keep pace with population growth for many years, the relevant tax base is small, and public debt is already high and growing fast. Despite all these important obstacles to success, the SEIA report concludes that no additional research into the costs, benefits, or risks of the NHI proposal is required.[22]

The 2019 SEIA report is thus far too superficial – and far too misleading – to provide people with the information they need to 'know about' the NHI Bill and make informed comments on it. In addition, the 2019 report has not been updated to take account of the economic impact of the prolonged Covid-19 lockdown, the Russia-Ukraine conflict, and an upsurge in consumer inflation in 2022 and 2023. Again, the effect is to undermine the public consultation process and further breach the Constitution's requirements.

National Policy Development Framework, 2020

The *National Policy Development Framework* (the Framework) was approved by the Cabinet in December 2020 and is intended to help give effect to the National Development Plan: Vision 2030. Towards this end, the Framework seeks to improve policy development by 'ensuring meaningful participation' and 'inculcating a culture of evidence-based policy making'.[23]

In a section dedicated to 'Stakeholder Engagement in Policy-Making', the Framework states: 'Chapter 10 of the Constitution prescribes that people's needs must be responded to, and the public must be encouraged to participate in policy-making. Therefore, the involvement of the public in policy-making is a constitutional obligation that government institutions must respect and institutionalise.' [24]

The Framework goes on to list some of the key requirements for proper public participation. 'Consultation with stakeholders should commence as early as possible', it says. All relevant stakeholders should be identified, including 'those who will benefit when [existing] problems are addressed' and 'those who will bear the cost of implementation of the proposed

[21] 2019 SEIAS Assessment
[22] 2019 SEIAS Assessment, p59
[23] National Policy Development Framework, 2020, p3
[24] Ibid, p19

intervention'. Policy-makers must also identify and counter all 'barriers to active participation' and ensure that 'consultation is infused in all aspects of the policy-making cycle'.[25]

According to the Framework, adequate thought must be given to 'which policy solutions would best achieve the public policy objective' and 'how best' the proposed policy solution can be implemented. Policy-makers must 'inform and engage stakeholders' on 'the nature and magnitude of a policy issue', along with its likely 'impacts and risks'. These assessments must be 'informed by the best available evidence, data and knowledge'.[26]

In addition, policy-makers must be willing to adjust their proposals in the light of the evidence provided. 'Policy-makers must not impose their preconceived ideas…and pre-empt the outcome of the policy consultation process. They need to be willing to be persuaded and acknowledge the input of stakeholders with a view to creating a win-win policy outcome'. They must also avoid any impression that 'the consultation process is staged, managed, cosmetic, token and a mere compliance issue'. Instead, they must 'strive to produce an outcome based on bargaining, negotiation, and compromise'.[27]

Policy-makers must also provide adequate feedback to those who have submitted comments. This must include 'rational reasons' as to why 'submissions and comments…were not consolidated into the final policy document'. In addition, policy-makers must 'report in the SEIAS (final impact assessment: consultation section) on the results of their early engagement with stakeholders'. They must explain 'what stakeholders viewed as possible solutions, benefits and costs and how these influenced the selection of the proposed policy solution'.[28]

All these important directions to policy-makers have been disregarded in the consultation process on the NHI Bill. Evidence-based analysis and sound alternative solutions have been rejected out of hand, while the consultation process has been turned into a meaningless tick-box exercise. Instead of relying on 'the best available…data and knowledge', as the Framework document requires, ANC MPs have 'imposed their pre-conceived ideas' about the NHI on all South Africans, regardless of the costs. Far from taking proper account of differing perspectives, they have also stigmatised opposition MPs and other critics of the Bill as 'not caring about the people of South Africa'.[29]

No real changes to the NHI Bill

The B11B version of the NHI Bill, as sent to the NCOP for adoption, is largely unchanged from the original, for the concerns of major stakeholders have been summarily brushed aside.

[25] Ibid, pp19-20
[26] Ibid, p20
[27] Ibid
[28] Ibid
[29] pmg.org.za/committee-meeting/36051, pp9, 10, 4

The South African Medical Association (SAMA), the country's largest doctors' organisation, which represents some 12 000 doctors in public and private practice, said in July 2023 (soon after the National Assembly had endorsed the Bill) that its concerns had been 'ignored since the discussions on the green paper' back in 2011. Said SAMA chair Mvuyisi Mzukwa: 'We have been making submissions, but there has never been any consultation or feedback… The public consultation processes undertaken by the government and parliament to date have been mere tick-box exercises.' This time around, SAMA's submission to the NCOP was thus accompanied by a petition signed by 52 000 people, which the organisation hoped would secure more attention for its views.[30]

SAMA is primarily concerned about the risk of corruption in the NHI Fund, the absence of any effective mechanism to deal with human resource shortages and infrastructure problems in the public healthcare system, the limits to be placed on medical schemes, and the absence of a cost assessment. Most of these concerns extend way beyond the wording of the Bill. Many people and communities outside the ranks of healthcare workers share SAMA's concerns, moreover, as evidenced by the number of signatories to its petition. Adds Dr Mzukwa: 'People don't trust the government… I was born in Flagstaff in the Eastern Cape. In my village there is still no water; it was promised in 1994. Now the government tells them it will give them a healthcare service under NHI. Yet there is not even a clinic. Communities there say there is no truth to this thing.'[31]

Discovery Health, the largest open medical scheme in the country, with more than 2.8 million members, is also concerned about the lack of proper consultation. According to Discovery CEO Ryan Noach, it is particularly worrying that 'the inputs of healthcare professionals, who are essential to the delivery of healthcare, were not given the appropriate weight and attention in the amendments to the Bill'. He also expressed surprise that the Bill had been adopted by the National Assembly despite 'the material concerns raised by almost all the opposition parties at the committee' – and even though the parliamentary legal adviser had questioned the constitutionality of some aspects of the Bill.[32]

Dr Noach further stressed his disappointment that 'the amended version of the NHI Bill varied so little from the original'. How the NHI was to be financed remained unclear 'as there had been no input from the National Treasury'. In addition, no clarity had been provided on the financial systems and controls that would be needed for effective oversight of the monies in the NHI Fund. Yet, 'without substantial financial support', necessary health system improvements could not be achieved or sustained. Added Dr Roach: 'The portfolio committee elected not to take the opportunity to make amendments to the Bill that would

[30] https://www.businesslive.co.za/bd/national/health/2023-07-24-snubbed-doctors-body-urges-mps-to-think-again-about-nhi/?
[31] https://www.businesslive.co.za/bd/national/health/2023-07-24-snubbed-doctors-body-urges-mps-to-think-again-about-nhi/?
[32] https://www.dailymaverick.co.za/article/2023-06-14-national-health-insurance-roll-out-one-step-closer-but-private-healthcare-has-burning-questions/

enhance both the feasibility and effectiveness of the NHI Fund, despite detailed and constructive inputs from multiple stakeholders.'[33]

The NHI Bill of 2019

The NHI Bill seeks to establish the NHI Fund, along with various other units that will be needed to implement the new system. However, the Bill fails to deal with a host of vital issues, as earlier outlined. This makes a mockery of the entire consultation process, as both the public and members of the NCOP have been denied the information needed to evaluate the likely costs and consequences of the measure.

In 2019, moreover, the then minister of health, Dr Zweli Mkhize, made it plain that the decision to embark on NHI had already been taken and could not be reviewed. 'That debate is over,' he said.[34] This indicates that ANC members of the NCOP are expected simply to rubber-stamp the Bill, rather than examine its merits. Yet all parliamentarians have a constitutional obligation to promote the best interests of the country – not the narrow concerns of the parties they represent.[35]

Parliamentarians also have an obligation to uphold the Constitution at all times. Hence, they cannot lawfully adopt the Bill unless they are satisfied – based on factual evidence and rational analysis – that the NHI will in fact increase, rather than diminish, access to healthcare; that it constitutes a 'reasonable measure' to enhance healthcare, that it can be implemented within the resources 'available' to the government, and that it does not breach any other constitutional provision.[36]

The Bill meets none of these criteria (see *Unconstitutionality of the Bill*, below). In addition, the NHI system is sure to be so costly and so damaging that there is little to be gained from a detailed evaluation of the clauses in the Bill. Focusing on specific clauses makes little sense when it is the bigger problems – going far beyond the wording of the Bill – that primarily need to be addressed.

One of the most important questions – yet to be answered – is the extent of the healthcare benefits the NHI Fund will be able to offer and sustain. This requires, among other things, an evaluation of the Fund's probable costs, how it can be financed, its capacity for efficient operation, and whether it will be able to safeguard its resources against corruption and other abuses. Proper consideration must also be given to alternative means of achieving universal health coverage – especially as these alternatives have far more realistic prospects of success than the NHI proposal.

The false claim at the heart of the NHI proposal

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[33] https://www.businesslive.co.za/bd/national/health/2023-05-25-litigation-threats-fly-as-soon-as-mps-adopt-nhi-bill/

[34] *The Citizen* 25 June 2019

[35] *Economic Freedom Fighters and others* v *Speaker of the National Assembly and Another*, [2017] ZACC 47

[36] Section 27, 1996 Constitution

The false claim underpinning the NHI proposal has long been that 'South Africa' spends 8.5% of its GDP on health – but that less than half of this (4.1%) goes to the public healthcare sector, on which 84% of South Africans rely, while more than half (4.4%) goes to private healthcare, which caters for only 16% of the population. This is said to result in 'a two-tiered health system', in which more than half of 'the overall health expenditure' goes to this 16%.[37]

However, this description conflates private spending on health services with tax-funded public expenditure. It also ignores the fact that the tax revenue allocated to public healthcare (R259bn in 2023/24) comes primarily from some 989 000 individuals, who pay almost three-quarters (72%) of all personal income tax collected.[38] These individuals then use their after-tax income to pay for the private healthcare of their choice.

Hence, it is not 'South Africa' that spends 8.5% of its GDP on healthcare but a relatively small group of taxpayers who pay substantial taxes to fund public healthcare for the majority of the population – and then pay again out of their own after-tax income for private health services. Many do so, moreover, because the defects in the public system leave them with little option but to seek private alternatives.

Still more importantly, the South African government has for many years allocated some 12% of the budget – equivalent to around 4.1% of GDP – to the funding of public healthcare. This proportion of GDP is more than most other emerging markets are able to spend and compares well with the 5% of GDP that the World Health Organization (WHO) recommends that governments should allocate to public healthcare. The real problem, thus, is not the size of the revenues being allocated to public health in South Africa each year – but rather the fact that these substantial monies are generally poorly used and often corruptly squandered.

As the *Financial Mail* has commented, the public healthcare system – despite the large revenues poured into it every year – remains a 'dysfunctional' one, in which 'theft of resources, crippling inefficiency, and accountability-free hospitals are the order of the day'. This is not 'a money problem', but rather 'a management one'. Hence, it cannot be resolved simply by throwing more revenue and other resources into public health.[39]

This malaise has been compounded by the ANC's insistence on cadre deployment, employment equity, and preferential BEE procurement. These interventions have stripped provincial health departments of experience and skills, put the management of hospitals and clinics into the hands of 'teachers, nurses, and even clerks with only a matric' (as the Development Bank of Southern Africa reported in 2011), eroded accountability, and

[37] *Daily Maverick*, 17 October 2019; NHI White Paper, 2017, para 71; Zweli Mkhize, 'NHI Bill: Refugees, inmates, selected foreigners and all children to benefit', *Politicsweb.co.za*, 8 August 2019; Nehawu, 'NHI: Access to health is a right', *Politicsweb.co.za*, 15 August 2019; *Business Day*, 20 August 2019; see also Zweli Mkhize, 'Mmusi Maimane has not studied NHI Bill properly', *Politicsweb.co.za*, 14 August 2019 and 2019 Medium Term Budget Policy Statement, p54

[38] Centre for Risk Analysis (CRA), *Public Finance*, August 2023, pp11, 12

[39] *Financial Mail* 1 August 2019

contributed to high levels of irregular spending.[40] These factors have in turn contributed to continual shortages of medicines, equipment, and other essential goods and services.[41]

In addition, health facilities are supposed to be maintained and expanded by the Department of Public Works and Infrastructure, but it frequently fails to do its job. Hence, as Michael Settas of the Free Market Foundation writes: 'There is a manifest lack of maintenance in public hospitals, which routinely record a litany of problems from malfunctioning elevators to backup electricity generators, geysers, air conditioners, water supplies, and safety equipment.'[42]

Moreover, if government policies were not so hostile to investment, growth, and employment – and if the government was willing to allow low-cost medical schemes and low-cost primary health insurance policies – then some 20 million more South Africans would already have access to private healthcare and the burden on the public system would be much reduced.

The real need is to extend the benefits of a competitive and independent system of private healthcare to millions more South Africans in these and other ways. Instead, the government is determined to terminate all medical schemes and bring private healthcare under comprehensive state control. It also wants a 'single-payer' system, under which the NHI Fund will have to pay for every single health service and item needed for the treatment of the entire population. This approach is sure to reduce available supplies and increase corruption and other abuses. It will also fail to meet the most pressing need of all – which is to reform the public healthcare system and so ensure that existing health revenues are far better used.

No remedy for public sector inefficiency

As earlier noted, the government currently spends around 4.1% of GDP on public health care, which is more than many other emerging economies can manage. But, despite the best efforts of many dedicated professionals working in the sector, the country gets little 'bang' for its substantial 'buck'. Instead, public health care is plagued by poor management, gross inefficiency, persistent wastefulness, and often corrupt spending.[43]

The upshot is that some 80% of public clinics and hospitals cannot comply with basic healthcare norms and standards, even on such essentials as the maintenance of hygiene and the availability of medicines. Cases of medical negligence – often involving botched operations or brain damage to newborn infants – have increased to the point where contingent liability for medico-legal claims against provincial health departments stood at roughly R120bn in the 2020/21 financial year. This was almost half the entire national healthcare budget. In the Eastern Cape, which has arguably the worst-run public healthcare system in the

[40] *Financial Mail* 10 June 2011, *The Star* 7 September 2012
[41] *Financial Mail* 6 June 2018
[42] https://dailyfriend.co.za/2022/08/06/the-public-health-system-is-it-under-resourced/?
[43] Anthea Jeffery, 'Pressing ahead with NHI Implementation', *@Liberty*, IRR, Issue 34, November 2017, *Business Day* 30 October 2019

country, medical malpractice liability significantly exceeded the entire provincial healthcare budget.[44]

By comparison, the Western Cape – which has similar financial, human, and health facility resources compared to other provinces – had a medico-legal liability of R80m, equivalent to 0.3% of the province's budget. The contrast in the performance of the Western Cape and the Eastern Cape was stark, for the two provinces have much the same per capita health budgets and populations needing public healthcare. If anything, the Eastern Cape has better resources, with 71 filled posts per 10 000 people as opposed to 60 such posts in the Western Cape. And yet the medico-legal liability of the Eastern Cape amounted to 139% of its budget while that of the Western Cape stood at 0.3%. This again shows that the main problem with public healthcare is not a lack of resources but rather a failure of management and accountability.[45]

The NHI makes no attempt to remedy these defects. Instead, it seems to assume that throwing more resources at the public sector will provide a cure-all, whereas poor skills, cadre deployment, and a crippling lack of accountability lie at the heart of the present malaise. These are thus the key problems needing to be overcome. But the NHI Bill is likely to make them even worse by concentrating an extraordinary degree of power over the entire healthcare system in a massive new bureaucracy operating under the largely untrammelled control of the health minister alone.[46]

A vast additional bureaucracy

The NHI will require a vast bureaucracy. This will start with the NHI Fund, into which all health monies will be placed and from which all health expenses will be paid. The NHI Fund will have nine subsidiary units to decide, among other things, on planning, 'benefits design', the payment of health providers, the accreditation process, the procurement of health products, the monitoring of performance, and the management of risk and investigation/prevention of fraud.[47]

Many other bureaucratic entities will also be needed. These include various advisory committees to be established by the health minister, along with new 'District Health Management Offices' in every municipal district, new 'Contracting Units for Primary Health Care' in every sub-district, and a new 'Health Products Procurement' unit' at the national level. A comprehensive 'National Health Information System' will also be needed and will (supposedly) determine the health needs of all South Africans (likely to number well over 60 million by the time the NHI takes effect). This information system will also monitor treatment utilisation patterns, assess financing requirements, and evaluate NHI systems for

[44] *Financial Mail* 19 July 2018, *Financial Mail* 14 November 2019, *Business Day* 30 October 2019; Michael Settas, 'NHI: A deserved monopoly on South Africa's healthcare?, Presentation to the Free Market Foundation, 21 November 2019; https://dailyfriend.co.za/2022/04/16/the-ancs-populist-nhi-delusion/; https://dailyfriend.co.za/2022/08/13/the-public-health-system-quality-outcomes-medicolegal-liabilities/
[45] https://dailyfriend.co.za/2022/08/13/the-public-health-system-quality-outcomes-medicolegal-liabilities/
[46] *Business Day* 7 November 2019
[47] Clause 20(3), NHI Bill

reimbursing health professionals and purchasing health goods. A new Appeal Tribunal will also be needed to deal with the many complaints against the NHI Fund that are likely to arise. Several other new entities will be required too. These will include, among various others, a Stakeholder Advisory Committee representing health professions councils, organised labour, civil society organisations, and patient advocacy groups, among other things.[48]

The Office of Health Standards Compliance (OHSC) – which will be responsible for assessing whether health facilities and health providers qualify to participate in the NHI – is already in existence but will require many more inspectors to cope with its increased responsibilities. It will have to assess all public health clinics and hospitals, currently numbering some 3 900, along with an (estimated) 41 000 private practices that might either wish to take part in the NHI or find themselves compelled to do so. The OHSC will be expected to reassess all NHI participants every five years, as the Bill requires. It will therefore need to review some 44 900 facilities every five years, or roughly 9 000 each year. This is almost 13 times more than the 730 facilities it managed to assess in the 2018/19 financial year, as further outlined below.[49]

The NHI Bill makes no attempt to quantify the overall costs of this enormous bureaucracy. The White Paper's estimate of likely NHI costs (see below) also overlooks these expenses.[50] Yet all these new administrative entities will have to be suitably staffed, remunerated, equipped, and provided with appropriate office or other working space. Already, moreover, the public service wage bill absorbs some 31% of budgeted spending – and some 40% of main revenue collected – and is crowding out vital spending on infrastructure and other needs.[51]

Silence on NHI costs

The NHI Bill is silent on the system's overall likely costs. The 2017 White Paper put the costs of the NHI in 2025, then the proposed starting date, at R256bn a year (in 2010 prices). However, this figure is outdated and has never been convincing. It was simply a 'guesstimate' that was 'thumb-sucked' by a local firm, as previous health minister Dr Aaron Motsoaledi has acknowledged.[52]

Dr Motsoaledi has also claimed that 'focusing on "what will NHI cost" is the wrong approach', as it is likely to 'require an endless cycle of revisions and attempts to dream up new revenue sources'.[53] That, however, is precisely the point. South Africa cannot 'dream up' new revenue sources – and especially not when the projected growth rate is down to 0.4%

[48] Jeffery, 'Pressing ahead with NHI Implementation', pp36-38; Anthea Jeffery, 'The NHI Proposal: Risking lives for no good reason, *@Liberty*, IRR, Issue 29, December 2016, p5; Clauses 24-27, 36-38, 34, 40, 44, NHI Bill; www.worldometers.info/world-population/south-africa-population
[49] CRA, *2023 Socio-Economic Survey of South Africa*, pp503-505; Clause 39(7), NHI Bill; https://dailyfriend.co.za/2022/08/13/the-public-health-system-quality-outcomes-medicolegal-liabilities
[50] White Paper, page 40, Table 1;
[51] https://www.treasury.gov.za/documents/national%20budget/2023/review/FullBR.pdf
[52] *businesstech.co.za*, 334169, 12 August 2019
[53] 2017 White Paper, pp39-40, paras 200-201

of GDP in 2023, the finance minister is slamming the brakes on spending because the budget deficit is likely to come in at some 6.5% of GDP in 2023/24, and the ratio of public debt to GDP is now set to rise to 75% by 2024/25 (see *NHI financing*, below).[54]

When Dr Mkhize released the NHI Bill in August 2019, he too shrugged off the vital costs issue. Instead, he stated that 'nothing should stand between us and the NHI – not even the cost'. Both he and President Cyril Ramaphosa have also stressed that 'the NHI will be implemented regardless of the costs'. Though this approach is simply irresponsible,[55] it has since been echoed by current health minister Dr Joe Phaahla, who told Parliament in November 2022 that 'the government is determined to press ahead with implementing NHI despite the fiscal constraints facing South Africa'.[56]

Adding to the confusion regarding costs are the many conflicting figures recently provided by ministers and senior health department officials. Dr Mkhize said in 2019, for instance, that it would not be enough to combine the amount then being spent on public health (R223bn in 2019/20) with what was spent in the private sector (R250bn in that financial year). He doubted whether 'the sum total of the two was enough to run the NHI', adding: 'I think we need more.' At other times, however, the minister indicated that a smaller sum (R440bn) would suffice.[57]

By contrast, Dr Olive Shisana, NHI advisor in the presidency, estimated at much the same time that the NHI would cost much less: R275bn a year at its 2026 start. The then deputy minister of health, Dr Phaahla, provided yet another figure, saying that R230bn a year would be sufficient for the NHI as most of its costs would be covered by 'restructuring' the current public healthcare budget.[58]

The deputy director general for the NHI, Dr Anban Pillay, had a different perspective. He stated that NHI costs could not be quantified in the abstract ('it can cost as much as we want it to cost'), and would thus depend on 'how much funding was available'. As he described it, the NHI's budget would vary from year to year, depending on how the economy was doing, which meant that the health services covered would fluctuate from year to year as well.[59]

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[54] South African Reserve Bank (2023), Statement of the Monetary Policy Committee (July 2023), p. 2-3, https://www.resbank.co.za/content/dam/sarb/publications/statements/monetary-policy-statements/2023/july-/Statement%20of%20the%20Monetary%20Policy%20Committee%20July%202023.pdf; CRA, *2023 Socio-Economic Survey of South Africa*, p204; https://www.businesslive.co.za/bd/economy/2023-09-06-rising-debt-imperils-budget-credibility-warns-michael-sachs/
Saturday Star 2 November, *Business Times* 3 November, *Business Day* 3 November 2019

[55] Mia Malan, 'The shot-caller and the NHI: can Zweli Mkhize pull this off?', *Daily Maverick*, 30 August 2019; Siviwe Gwarube, 'Urgent clarity needed from Treasury regarding NHI funding', *Politicsweb.co.za*, 26 August 2019

[56] https://www.businesslive.co.za/bd/national/health/2022-11-17-state-will-press-ahead-with-nhi-regardless-of-state-of-economy-phaahla-says/

[57] 'NHI Bill: Minutes of briefing to the Portfolio Committee on the NHI Bill by the minister, deputy minister, and state legal adviser', 29 August 2019; Mia Malan, ibid

[58] Staff writer, 'Special advisor to president answers 6 burning questions about the new NHI in South Africa', *businesstech.co.za*, 22 August 2019; *Business Report* 30 August 2019

[59] *Sunday Times* 25 August 2019

This further underscores the unacceptable vagueness of the NHI proposal. On this approach, moreover, many of the health professionals who have agreed to participate in the NHI could be left high and dry (perhaps for years at a time), whenever the NHI budget proves insufficient to cover the health services they have been contracted to provide. Given the many pressures on the fiscus, millions of South Africans will also in practice be denied the NHI health benefits they have been encouraged to expect. Again, it is irresponsible for the government to forge ahead with the Bill in these circumstances.

A realistic estimate of likely NHI costs must be developed before the Bill is adopted. The Department of Health has recently estimated NHI costs at R200bn a year, but this figure has not been explained and Discovery Health believes the cost will be double this sum.[60]

In August 2022 the Solidarity Research Institute echoed Dr Mkhize in suggesting that likely NHI costs can be calculated by adding the projected costs of both public and private healthcare in the years ahead. Assuming that costs rise by some 5.5% a year from 2024 onwards, Solidarity believes that the NHI would cost R659bn in 2026 (when the new system has long been expected to begin).[61]

On this basis, with health inflation assumed to keep rising at 5.5% a year (which is likely to be too optimistic, given the declining value of the rand and the international tendency of healthcare costs to rise faster than inflation), the NHI is likely to cost some R816bn in 2030, R1 067bn in 2035, and R1 394bn in 2040.[62] Public spending of this magnitude on health care within a scant 15 years of the NHI's introduction is completely unaffordable.[63]

At the same time, the Bill offers no meaningful way to bring down healthcare costs. Like the White Paper before it, the Bill simply assumes that the NHI Fund will significantly reduce healthcare costs by introducing 'a single-payer and single-purchaser fund', which will 'leverage its monopsony power' to 'strategically' purchase services and achieve major 'economies of scale'.[64] (A monopsony arises where one buyer interacts with many would-be sellers and thus has considerable market power.)

However, monopsony power will clearly have less impact in practice than the government's proposed price controls. Under the Bill, the NHI Fund will have pervasive control over all healthcare prices: from the 'recommended' prices of aspirin and rubber gloves to the fees payable to GPs, surgeons, and other specialists. The NHI Bill assumes that these price

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[60] https://dailyinvestor.com/south-africa/27651/nhi-needs-r296-billion-more-from-south-african-taxpayers/

[61] https://dailyinvestor.com/south-africa/27651/nhi-needs-r296-billion-more-from-south-african-taxpayers/

[62] https://dailyinvestor.com/south-africa/27651/nhi-needs-r296-billion-more-from-south-african-taxpayers/; see also health Table 2: Health expenditure in SA public and private sectors, 2012/13-2019/20, 2017 White Paper, p42

[63] *Financial Mail* 15 August 2019; Helanya Fourie, 'Unpacking health inflation in South Africa', *Econex Blog*, 16 August 2019, p2; AfriForum, 'Eternal junk status will follow implementation of NHI', *Politicsweb.co.za*, 12 November 2019; IRR, *2019 South Africa Survey*, Johannesburg, 2019, p192

[64] 2017 White Paper, pp49-50

controls will be effective in cutting costs while enhancing quality. However, the more likely outcome is that many valuable medicines, medical devices, health technologies, and diagnostic tests will be ruled out as too costly.

In addition, without a market mechanism to help determine needs, officials will have to decide what health goods and services are likely to be required at different times and in different places. Since officials will not be able to predict the annual health needs of more than 60 million people, they will inevitably over-estimate some needs and under-estimate others. This in itself will make for major inefficiency. Bureaucratic control will also stifle innovation and promote corruption, adding to overall costs.

Moreover, no amount of 'strategic' purchasing by a centralised fund can address the major drivers of healthcare costs. These are increasing utilisation rates resulting from an ageing population, high levels of chronic disease, and the rising costs of new medicines and technologies, compounded by the falling value of the rand.[65] The NHI's single-payer model does not address these drivers and so cannot succeed in reducing healthcare costs – a fact that needs to be acknowledged, not brushed aside.

NHI financing

The NHI Bill overlooks the vital question of how the new system is to be financed. When Dr Mkhize was health minister, he discounted this key issue on the simplistic basis that 'in the long term, the investment in NHI will create a funding mechanism that will permanently resolve underfunding.'[66] This claim is particularly unconvincing now, with tax revenue falling some R80bn below projections, public spending continuing to grow faster than the February 2023 budget anticipated, and little prospect that the tax take can be significantly increased.[67]

A comprehensive Treasury paper on NHI costs and financing has long been promised but has still to be published. In the absence of this paper, the 2017 White Paper simply assumed that a mere R72bn in additional revenue would be needed to fund the NHI when it became fully operative in 2025. The White Paper also estimated that this shortfall could be met via a 4% surcharge on taxable income, a one percentage point increase in the VAT rate, a new payroll levy, or some combination of these additional taxes.[68]

In August 2022, however, the Solidarity Research Institute pointed out that the NHI was likely to cost R659bn in 2026, as earlier described. In Solidarity's view, existing taxes could contribute R363bn (5% of projected GDP) of the total required, but this would leave a shortfall of R296bn still having to be met. According to Solidarity, this R296bn could in theory be raised by removing the existing medical scheme tax credit (worth about R30bn a

[65] Paul Harris and Julia Price, 'Discussion Paper on Access to Healthcare in South Africa and the Proposed National Health Insurance Plan, Prepared for the High Level Panel of Parliament', 26 June 2017, pp6, 13-14
[66] *Sunday Times* 14 July 2019
[67] https://dailyinvestor.com/finance/29952/enoch-godongwanas-r82-billion-headache/
[68] *Legalbrief* 15 July, *Business Day* 30 October 2019; 2017 White Paper, p47, Table 3

year) and levying some combination of the following taxes: a 40% surcharge on personal income tax, a payroll tax of 13.4%, a VAT rate of 22% (up from 15% now), or a corporate income tax rate of 45% (up from 27%). In practice, however, these additional taxes would be unlikely to yield the additional revenue required as 'the South African taxpayer is already over-taxed' as Solidarity warned.[69]

Discovery Health has also tried to estimate the magnitude of the new taxes that will be needed to fund the NHI. On the (unlikely) assumption that the additional revenue required will be limited to R200bn, as the Department of Health has claimed, Discovery estimates that this sum could be obtained by raising the VAT rate to 21.5%, increasing personal income taxes by 32%, or introducing a payroll tax at ten times current UIF contributions (or through some combination of the three). Yet even these big tax increases 'will only get the government to around 50% of what the NHI requires', warns Dr Roach. In practice, moreover, attempting to increase taxes in this way will lead to 'a tax revolt'.[70]

Business Unity South Africa (BUSA) and Business For South Africa (B4SA) agree with Discovery's assessment. They warn that 'huge' tax increases of this kind are 'obviously unworkable as South African taxpayers are already under extreme financial pressure and any increases are bound to affect them materially'.[71]

Part of the resistance will come from the fact that significant tax hikes have already been introduced. Among other things, the VAT rate was increased by 1 percentage point (from 14% to 15%) in April 2018, while the top marginal rate of personal income tax was hiked by 4 percentage points (from 41% to 45%) at the same time. This means that two of the tax increases the White Paper earlier assumed could be used to help fund the NHI have already been introduced to pay for other government spending.[72] (In addition, the increase in the top personal income tax rate has yielded far less additional revenue than the government had earlier expected, which further confirms that additional tax hikes are not a sound solution.)[73]

The NHI Bill remains unacceptably vague on how the necessary financing is to be secured. It speaks of using general tax revenue, supplemented in time by an (unspecified) payroll tax and an (unspecified) 'surcharge on taxable income'. In addition, it proposes the reallocation to the NHI Fund of some R150bn in national revenue that currently goes to provincial health administrations as part of their 'equitable share'. It also suggests that conditional grants (such as the comprehensive HIV, AIDS, and TB grant) should be shifted to the NHI Fund, and that

[69] https://dailyinvestor.com/south-africa/27651/nhi-needs-r296-billion-more-from-south-african-taxpayers/

[70] https://dailyinvestor.com/south-africa/27651/nhi-needs-r296-billion-more-from-south-african-taxpayers/

[71] https://www.businesslive.co.za/bd/national/health/2023-08-29-business-groups-drop-nhi-tax-bombshell/

[72] 2019 SEIAS assessment, pp26-27; www.sars.gov.za, 27 March 2018; *Fast Facts*, IRR, Johannesburg, February 2018, p11

[73] Nazmeera Moola, 'Government doesn't seem to grasp the meaning of SA's parlous financial condition', *Daily Maverick*, 13 November 2019

medical scheme tax credits should be terminated.[74] However, these reallocations will not yield the substantial new revenues needed to fund the NHI.

In addition, the Bill brushes aside the fact that South Africa's tax burden is already very high. Even without any additional NHI taxes, the country's 'total revenue-to-GDP ratio is higher than 20 other emerging markets and five developed economies: the United States, Switzerland, South Korea, Australia, and Israel'. Given this situation, there is simply 'no room to institute new taxes' to fund the NHI, as the *Financial Mail* reports.[75]

Important too is the small size of the tax base. Though 23.8 million individuals were registered for personal income tax in 2021 (the latest year for which these figures are available), most had earnings below the tax payment threshold. Hence, only 5.5 million people out of the 23.8 million were assessed for tax in that year. (By contrast, 5.9 million individuals had been assessed in the 2013/14 tax year, which shows that the tax base is already shrinking.) In addition, some 72% of the R555bn in personal income tax that was paid in 2021 came from roughly 989 000 people with annual taxable incomes of R500 000 or more.[76]

Much of the country's tax burden thus rests on a very small group of individual taxpayers. Hence, if increased taxes and reduced health services under the NHI were to encourage half of the people with annual incomes exceeding R500 000 to emigrate, the personal income tax that could be collected would be reduced by roughly a quarter. This would make it far harder for the government to sustain its spending on the public sector wage bill, social grants, infrastructure, and a host of other needs.

NHI taxes unlikely to be 'ring-fenced' for NHI needs

Most commentators on NHI financing seem to assume that any additional revenues raised via new 'NHI' taxes will be ring-fenced and used solely to fund the NHI. The more likely scenario is that they will be paid into the South Africa's National Revenue Fund and used for all types of government spending. This is also what the Constitution requires, for Section 213 states that 'all money received by the national government must be paid' into this general fund – unless this rule has 'reasonably' been excluded under legislation expressly providing for this.[77]

Whether such legislation will be adopted is far from clear. In a briefing to the health portfolio committee on the NHI Bill in August 2019, Dr Mkhize said that the Treasury was 'not comfortable with earmarking funds' for particular purposes as 'surplus' revenue could then not be used for other needs. The minister added that the Treasury had not entirely excluded a

[74] Clause 49, NHI Bill; Memorandum on the Objects of the NHI Bill, para 8.8
[75] *Financial Mail* 4 September 2019
[76] CRA, Public Finance, August 2023, pp10-12
[77] Section 213 (1), 1996 Constitution

ring-fencing option for the NHI[78] – but this is hardly an adequate assurance that 'NHI' taxes will in fact be used for NHI purposes.

If the necessary ring-fencing statute is not in fact adopted, then 'NHI' taxes will be paid into the general revenue fund – as already happens with the proceeds of the 'sugar' and 'carbon' taxes, and the 'plastic bag' levy before them. This situation would also echo what happens in Canada, which has a single-payer health system similar in some ways to the proposed NHI.

In Canada, reports the Fraser Institute, a think tank, most people are kept in the dark as to how much of their taxes goes to fund the health system. In 2019 the Fraser Institute filled this gap by identifying what portion of the general taxes paid by the average middle-class family was used for the health system. It also found out that the tax revenues such a family contributed to the health system had increased in real terms (after adjusting for inflation) by 66% over the past 20 years or so.[79]

The Canadian experience suggests that a key – though, of course, unstated – purpose of the NHI is to justify the imposition of major additional taxes, rather than improve the quality of healthcare. Moreover, if tax increases of the Canadian magnitude are implemented in South Africa, the impact on taxpayers is likely to be devastating. The poor will be hit hard by payroll taxes – which could limit employment – and also by increased VAT. Middle class people with scarce skills will increasingly be unable (and unwilling) to pay large tax bills for tardy and inadequate NHI services. This could prompt many of them to emigrate, thereby further reducing an already very narrow tax base.

Key warnings that the NHI is unsustainable and unaffordable

Even before the Covid-19 lockdown began in 2020, economic growth had faltered badly, coming in at 1.6% in 2018 and a meagre 0.3% in 2019. In 2020, after many months of lockdown restrictions, the economy shrank by a staggering 6%. Though GDP growth rebounded off this low base to 4.7% in 2021, it then dropped again to 1.9% in 2022.[80] The country now confronts the risk of 'stagflation' – a damaging combination of stagnant growth and high inflation – with the South African Reserve Bank (SARB) in July 2023 forecasting dismal growth of 0.4% in 2023, 1.0% in 2024 and 1.1% in 2025.[81]

In addition, the fiscus already faces a budget deficit of at least 4.8% of GDP in the 2023/24 financial year.[82] South Africa's public debt has also been rising very rapidly since 2008,

[78] 'NHI Bill, Briefing with minister, deputy minister & legal opinion', *PMG summary*, 29 August 2019, p6
[79] *Health Policy Studies*, Fraser Institute, 'Annual health-care costs for typical Canadian family eclipse $13 000 this year', 8 August 2019
[80] Stats SA (2023), Statistical Release P0441: Gross Domestic Product, First quarter 2023, p. 9. https://www.statssa.gov.za/publications/P0441/P04411stQuarter2023.pdf, retrieved on 15 August 2023.
[81] South African Reserve Bank (2023), Statement of the Monetary Policy Committee (July 2023), p. 2-3, https://www.resbank.co.za/content/dam/sarb/publications/statements/monetary-policy-statements/2023/july-/Statement%20of%20the%20Monetary%20Policy%20Committee%20July%202023.pdf, retrieved on 15 August 2023
[82] CRA, 2023 *Socio-Economic Survey of South Africa*, p206

when it stood at R627bn or 26% of GDP. Even without the NHI, public debt will exceed R5 trillion in the current financial year (74.4% of GDP) and is expected to rise to R5.3 trillion (75% of GDP) by 2024/25.[83]

The government's inability to contain rapidly rising public debt has already prompted the three main international ratings agencies to downgrade South Africa's sovereign debt to sub-investment or junk status. If public debt cannot convincingly be controlled, further ratings downgrades are sure to follow. This will harm the economy and greatly increase the government's debt-servicing costs, which already amount to R341bn or almost R1bn a day. These costs are already far higher than the R259bn budgeted for public healthcare in the current financial year.[84] In addition, the International Monetary Fund has recently warned that debt service costs could spiral to three times the current health budget within five years. Yet the more debt servicing costs, the more this will crowd out spending on education, healthcare, housing, social grants, and other vital needs.[85]

Also important is the Davis Tax Committee's warning that financial constraints are likely to render the NHI system 'unsustainable'. Having carefully examined the issue of NHI funding, the committee reported in March 2017 that 'substantial increases' in VAT or personal income tax, or the introduction of a new social security tax, would be needed. It also said (emphasis as in the original) that '*the proposed NHI, in its current format, is unlikely to be sustainable unless there is sustained economic growth'*. It further cautioned that 'the magnitudes of the proposed NHI fiscal requirements are so large that they might require trade-offs with [ie, reductions in] other laudable programmes', such as increased funding for post-school education or 'social security reform'.[86]

The Davis Tax Committee's 2017 warning that the NHI is 'unsustainable' was later echoed by the National Treasury. In its medium-term budget policy statement in October 2019, the Treasury stated that NHI costs 'were no longer affordable', given the country's current 'macroeconomic and fiscal outlook'. It also recommended that NHI plans should be significantly scaled back.

Despite repeated requests by opposition parties that the Treasury provide a comprehensive report on the financial feasibility of the NHI, this has not yet been done. In November 2022, however, in reply to a DA parliamentary question asking for a 'cost model', finance minister Enoch Godongwana made it clear that such a model 'would not automatically translate into budget allocations'. On the contrary, revenue allocations to the NHI 'would have to be made

[83] Ibid, p204
[84] https://www.treasury.gov.za/documents/national%20budget/2023/review/FullBR.pdf
[85] Moola, 'Government doesn't seem to grasp', ibid; https://www.biznews.com/undictated/2023/09/11/magnus-heystek-south-africa-economic-catastrophe
[86] The Davis Tax Committee, 'Report on Financing a National Health Insurance for South Africa', March 2017, p44

as part of the budget process, which would take into account the macroeconomic environment and fiscal space'.[87]

All that remains clear, thus, is that both the National Treasury and the Davis Tax Committee are agreed that the NHI is unaffordable. In these circumstances, it makes no sense at all to proceed with the NHI Bill. Instead, the government should focus on ensuring that the large sums committed to public healthcare over the next three years – some R764bn from 2022 to 2024[88] – are properly administered and spent.

Questions about the healthcare services to be provided

The NHI Bill is silent on the healthcare benefits the system will provide, saying that these will be decided in due course by the proposed 'Benefits Advisory Committee' in consultation with the health minister and the board of the NHI Fund.[89]

According to the June 2017 White Paper, the NHI is to cover cardiology, dermatology, neurology, oncology, psychiatry, obstetrics, gynaecology, paediatrics, orthopaedics, and surgery, including organ transplants of various kinds. At the primary health care level, it will provide 'sexual and reproductive' healthcare, along with optometry, 'oral health rehabilitation', and a comprehensive range of remedies for mental disorders and disability needs. Treatment for 'rare diseases' and 'dread diseases' will also be covered.[90]

This is an impressive list. In practice, however, the government will not have the R659bn (or even more) that will probably be needed, in 2026 alone, to provide all these services to a population sure to number well over 60 million by then. Demand is also likely to increase very strongly once all South Africans have been given the right to 'free' health services at all public and private facilities. People, and not only South Africans, will flock in their millions to hospitals, specialists, doctors, and other providers for the treatment supposedly on offer through the NHI. Soon, however, they will find that there are not nearly enough resources available to meet the scale of need.

People will thus have to wait for weeks, months, or years for NHI services. A similar outcome is evident even in wealthy Canada, where waiting times to see a specialist and then be treated have almost tripled from 9.3 weeks in 1993 to 27.4 weeks in 2022.[91] Yet Canada's health system is far better resourced than South Africa's, while Canadians also have the choice of crossing into the US to seek treatment there. Many take advantage of this option, thereby reducing the pressure on the Canadian system in ways that will not be available in South Africa. In addition, 65% to 75% of Canadians have some form of supplementary health

[87] https://www.politicsweb.co.za/politics/finance-minister-wont-commit-to-nhi--da?
[88] CRA, 2023 *Socio-Economic Survey of South Africa*, p474
[89] Clause 25(5), Bill
[90] 2017 White Paper, pp3, 24, 25, 27
[91] Fraser Institute, 'Waiting your Turn, Wait Times for Health Care in Canada, 2022 report', 8 December 2022, https://www.fraserinstitute.org/categories/health-care-wait-times#:~

insurance[92] – whereas the South African government plans to terminate almost all medical schemes and primary health insurance once the NHI comes fully into operation.

Also relevant is a 2015 World Bank study of 24 developing countries, all of which had promised universal health coverage but none of which were in fact able to deliver this. In each country, said the Bank, there was a significant 'gap between the free comprehensive benefit package promised...and the de facto actual benefits'.[93] South Africa, with its very high unemployment rate, limited resources, and proclivity for inefficiency and corruption is unlikely to do better than these other states in delivering the health benefits it has promised.

Fraud and corruption

The enormous amount of revenue over which the NHI Fund will preside is sure to become a magnet for corruption, especially in procurement. In October 2016 Kenneth Brown, then chief of procurement at the National Treasury, warned that between 30% and 40% of the government's procurement budget (worth R600bn at that time) was tainted by 'inflated pricing and fraud'.[94]

The problem has since grown worse, for in August 2018 the acting chief procurement officer, Willie Mathebula, told the Zondo commission of inquiry into state capture that 'the government's procurement system is deliberately not followed in at least 50% of all tenders'. In addition, once the usual tendering rules have been suspended on some spurious basis (a claimed emergency, for instance), 'a contract which starts at R4m is soon sitting at R200m'. These abuses have a huge impact on service delivery, for the government is 'the biggest procurer of goods and services, spending an estimated R800bn a year'.[95]

The state's current annual procurement bill is considerably larger than R800bn. According to the first part of the Zondo commission's report, published in January 2022, state procurement amounted to R967bn by 2017.[96] It is now almost R1 trillion a year.[97]

When the NHI Fund takes charge of all the procurement contracts required to meet the health needs of more than 60 million people, this will provide many more opportunities for 'tenderpreneurs' to feather their own nests. Unless such abuses can effectively be countered – and the Bill offers no effective means of doing so – the hundreds of billions of rands in the NHI's annual procurement budget will increasingly become compromised by corruption.

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[92] *Sunday Times* 8 September 2019; see also Wikipedia, Health Care in Canada, https://en.wikipedia.org/wiki/Healthcare_in_Canada

[93] The Davis Tax Committee, 'Report on Financing a National Health Insurance for South Africa', March 2017, pp44, 21

[94] *Business Day* 13 October 2016

[95] *News24.com* 21 August 2018

[96] Judicial Commission of Inquiry into State Capture, Part 1, para 327 (Zondo Report) https://www.bowmanslaw.com/insights/government-contracting-and-public-sector-procurement/south-africa-public-procurement-cast-into-uncertainty-by-constitutional-court-judgment/

[97] https://www.bowmanslaw.com/insights/government-contracting-and-public-sector-procurement/south-africa-public-procurement-cast-into-uncertainty-by-constitutional-court-judgment/

The 2019 SEIA report acknowledges that there is a 'high' risk of fraud and corruption in the NHI system. But it brushes the problem aside, saying the risk will be countered by the 'transparent appointment of appropriately qualified personnel' and the use of an electronic 'risk' engine to identify and 'address' all 'fraudulent activities on the part of providers and users'.[98]

However, why 'appropriately qualified' staff should be immune to the lure of lucrative tenderpreneurship is not explained. Nor is any attempt made to show how electronic risk management will prevent abuses which other state entities have signally failed to overcome over many years. Fraud mitigation is a major challenge even for highly innovative and well-resourced private insurers. The risk for them is that, if they get it wrong, they may be overtaken by competitors or even go out of business altogether. The NHI, by contrast, will face no such pressures. There is little likelihood, thus, that these paltry measures will be enough to prevent NHI procurement from being tainted by corruption on a massive scale.

The way in which the NHI Fund is to be structured and governed will further compound the risk. As the *Financial Mail* reported in 2019, the board of the Fund will 'ultimately be picked by the health minister, which means that multi-billion health contracts will be under the control of a few people hired by politicians'. This structure was 'designed for patronage', said Professor Alex van den Heever of Wits University. Commented *Business Day* in an editorial: 'A model [in which] the minister has the power to hire and fire every key position at board and executive level…leaves institutions wide open to capture by politically connected interest groups and renders them vulnerable to corruption.'[99]

This inadequate model remains essentially unchanged in the current version of the Bill. Though Board members must now be approved by the Cabinet before they are appointed by the health minister, the executive remains fully in charge of the process. The same applies to the dissolution of the Board, which now also requires Cabinet approval but is not subject to any independent checks and balances.[100]

In 2019 Dr Mkhize acknowledged that 'concerns around the NHI Fund being a possible vehicle for corruption and ending up like beleaguered SOEs, such as Eskom, are valid and need to be faced and answered'. But he had no concrete ideas on how to counter corruption. Instead, he relied on empty platitudes, saying: 'We must not fear corruption, we must fight it and dismantle it… For the NHI, corruption is a threat but we are armed'.[101] With what 'we are armed' he did not explain.

In addition, corruption in public health is already widespread, costing the system an estimated R40bn a year. As Mr Ramaphosa noted in 2019, at the launch of a 'Health Sector Anti-

[98] 2019 SEIAS assessment, p45
[99] *Business Day* 7 November 2019
[100] Clause 13(3)(b), Clause 13(9) to (11)
[101] *City Press* 11 August 2019

Corruption Forum' (the Forum), 'citizens are [sometimes] forced to make payments to get access to medical treatment either at [rates] above the official rate or for services that are meant to be free'. In addition, 'state property in hospitals and clinics, including vehicles and equipment, is being stolen, hired out, or resold'.[102]

Moreover, said the president, suppliers of health goods were often 'involved in false invoicing, collusion, and price fixing, especially on medicines'. The health supply chain was particularly vulnerable to corruption, he added, 'because of the large volume of goods and services transacted'. Common abuses included 'fraudulent orders, tender irregularities,…bribery, and over-pricing'. There was often also 'political interference in the tendering system', along with 'a lack of consequence management and an inadequate response from the criminal justice system'.[103] Effective action was thus vital in the run-up to the NHI to ensure that its 'pool of funds…was not wiped out through fraud and corruption', he said.[104]

In his speech at the Forum's launch, the president appealed to the public not to 'pay bribes to get treatment', not to 'offer money for securing or keeping a job in a clinic', and 'not to buy equipment and medicines you know to be stolen'. But such exhortations are clearly not enough. Prosecution and punishment are also needed – which is why the Hawks (the Directorate for Priority Crime Investigation) and the National Prosecuting Authority (NPA) have been included in the Forum.[105]

However, both the Hawks and the NPA lack the resources needed to fulfil even their current obligations. In 2019, for example, the Hawks had less than half their required staff complement, which meant that their 1 700 investigators were already working on almost 19 000 cases. The NPA had a high vacancy rate, a serious shortage of senior prosecutors, and an inadequate budget.[106] Both entities are now battling to deal with the many serious cases of corruption described in the Zondo commission's voluminous reports into state capture. They thus have little capacity to counter existing healthcare corruption, let alone the upsurge likely to occur under the NHI.

Predictably, the Forum proved unable to prevent a sharp increase in corrupt tendering during the Covid-19 lockdown. The relevant disaster management rules allowed the state to procure personal protective equipment (PPE) and other essential supplies on an emergency basis, without having to comply with all Treasury rules. Fraud and other irregularities thus abounded in the R152bn soon spent on PPE and other items.[107] In 2021 the Special Investigation Unit (SIU) said it had managed to investigate about 10% of these contracts, of

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[102] *Mail & Guardian* 4 October 2019; President Cyril Ramaphosa, 'Launch of Health Sector Anti-Corruption Forum', *Politicsweb.co.za*, 1 October 2019, pp2-3
[103] President Cyril Ramaphosa, 'Launch of Health Sector Anti-Corruption Forum', *ibid*
[104] https://www.timeslive.co.za/politics/2019-10-02
[105] Ibid, p3; Nehawu, 'Health Anti-Corruption Forum welcomed', Politicsweb.co.za, 2 October 2019
[106] *The Citizen* 3 October 2019
[107] Ibid; Nehawu, 'Health Anti-Corruption Forum welcomed', Politicsweb.co.za, 2 October 2019; https://neasa.co.za/empoweringsa-the-ancs-manipulative-anti-corruption-ploy/

which no fewer than 62% were irregular. Where irregular contracts had been examined, moreover, it was clear that one out of every two rands spent had been stolen through inflated pricing and/or a failure to deliver.[108]

Major inefficiencies within the NHI Fund

Even if fraud and corruption can be countered, the problem of inefficiency is likely to remain. If the NHI Fund is anything like other state entities – the public service, Eskom, Transnet, Prasa, Portnet, and the South African Post Office – its administration will be grossly flawed and ineffective.

The ruling party's long-standing commitment to cadre deployment, as set out in its *Cadre Policy and Deployment Strategy* in 1998, plays a major part in this pervasive inefficiency.[109] As the state-funded Human Sciences Research Council (HSRC) reported in 2012, 'the ANC's deployment strategy systematically places loyalty ahead of merit and even of competence and is therefore a serious obstacle to an efficient public service',[110] whether in healthcare or elsewhere. Often, moreover, cadres cannot be disciplined by their line managers because they answer rather to the deployment committees responsible for their appointments.[111]

In addition, the NHI Fund is likely to be a hugely magnified version of two existing funds, both of which have long been plagued by major inefficiency. The (workmen's) Compensation Fund receives some R9bn a year in employer contributions, from which it pays for the treatment of people who are injured or fall ill at work. However, the Compensation Fund is notoriously dysfunctional. Its internal controls have 'totally collapsed' – as Parliament's standing committee on public accounts (Scopa) noted in May 2021 – and it is so beset with 'corruption, malfeasance, maladministration, and wasteful expenditure' that the Auditor General would stop trying to audit it if this was not a statutory obligation.[112]

The dysfunctionality of the Compensation Fund weighs heavily on the doctors and other health providers called upon to treat injured and sick workers. As *Business Day* commented in an editorial in 2021, these providers 'find it extremely difficult to register and submit claims and often have to wait up to two years to be paid out'. To overcome this problem, many health professionals pay fees to third party administrators, who buy their claims and then take on the difficult task of submitting them to the Compensation Fund. The cash paid to

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[108] https://www.politicsweb.co.za/opinion/the-nightmare-of-national-health-insurance; https://www.702.co.za/articles/437335/friends-and-families-grabbed-cash-siu-finds-62-of-covid-19-contracts-irregular

[109] Helen Suzman Foundation, 'Party personnel agency', Focus 15 3rd quarter 1999; politicsweb.co.za/a-new-broederbond-only-more-ambitious; see also Joel Netshitenzhe, 'The National Democratic Revolution – Is it still on track? Umrabulo (4th quarter 1996), pp4-6

[110] *The Times* 13 July 2012, *The Citi*zen 10 May 2013; see also Anthea Jeffery, BEE: Helping or Hurting? Tafelberg, Cape Town, 2014, p97

[111] Anthea Jeffery 'The NHI Proposal: Risking lives for no good reason', *@Liberty*, IRR, Issue 29, December 2016, p63-64

[112] https://www.businesslive.co.za/bd/national/2021-05-19-scopa-demands-forensic-probe-into-compensation-funds-total-collapse/?; https://www.biznews.com/thought-leaders/2021/02/20/healthcare-system

health professionals allows them to keep practising – and also to keep treating Compensation Fund patients. As *Business Day* puts it: 'If it were not for this method of securing payment, many medical service providers would opt not to treat workers who are injured or become ill at work, as the SA Medical Association has warned.'[113]

Since 2019, however, the government has been intent on putting an end to this third-party payment system, whether by legislation or regulation. No good reason has been provided for the proposed change. According to *Business Day*, 'one possible reason for the proposed amendment is that administrators with their aggregated power have often successfully taken the Compensation Fund to court to get paid. Individual medical service providers would find it harder to do so.'[114]

What matters most for present purposes is that health providers clearly cannot rely on the Compensation Fund for the efficient processing of a far smaller number of claims than the NHI Fund will be called upon to handle. In addition, the government seems intent on terminating a practical solution to this problem which health providers have been using for some 20 years. The government has shown, moreover, that it cares little for the plight of unpaid health providers or the patients they may no longer be able to treat. Nor does it have the will to tackle the underlying problem – which is the 'absolute chaos' at the Compensation Fund, as Scopa has described it.[115]

A similar story is evident at the Road Accident Fund (RAF), which collects more than R40bn a year from the fuel levy and is supposed to pay the claims of people injured in road accidents. The RAF is technically insolvent, owing more than R300bn in unpaid claims. It received a disclaimer from the Auditor General for its 2021/22 financial statements after adopting new accounting methods that the Auditor General said materially obscured its true liabilities and assets.[116]

Court-ordered deadlines for payment have so often been ignored that 'more than 1 000 warrants of execution are received from sheriffs every month...and it is common for RAF assets to be attached, removed, and sold', as the organisation acknowledged in February 2017.[117] In June 2023, moreover, an oversight visit by Scopa members to the RAF's claims office in Pretoria found that the situation was even more chaotic.

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[113] https://www.businesslive.co.za/bd/opinion/editorials/2021-02-04-editorial-first-fix-the-broken-compensation-fund/

[114] https://www.businesslive.co.za/bd/opinion/editorials/2021-02-04-editorial-first-fix-the-broken-compensation-fund/

[115] https://www.businesslive.co.za/bd/opinion/2021-09-22-tim-hughes-rogue-regulations-are-set-to-deepen-the-rot-in-compensation-fund/

[116] https://www.businesslive.co.za/bd/opinion/editorials/2023-07-05-editorial-raf-cutting-its-nose-to-spite-its-face/; https://www.businesslive.co.za/bd/national/2023-06-25-raf-board-must-go-says-scopa/

[117] *Saturday Star* 24 August 2019, *Business Day* 12 November 2019; Paul Harris and Julia Price, 'Discussion Paper on Access to Healthcare in South Africa and the Proposed National Health Insurance Plan, prepared for the High Level Panel of Parliament', 26 June 2017, p8; *The Star* 4 February, *The Times* 16 February, *Business Day* 2 June 2017

As *Business Day* reports, 'boxes of claims by road accident victims were piled up in offices, in the corridors, and in the basement parking lot. And because the office furniture had been attached by the sheriff, staff were sitting on boxes and sharing improvised desks made of panels'. In the midst of this 'truly chaotic situation' (said DA MP Alf Lees) it was no wonder that 'claimants waited sometimes for years to have their claims settled, and often only got paid as a result of default court judgments'.[118]

In July 2023 lawyers representing the Law Society of South Africa, the Black Lawyers' Association, the National Democratic Lawyers' Association, the South African Medico-Legal Association, and six other organisations compiled a joint memorandum on the 'crisis' at the RAF. They said they were speaking on behalf of road accident victims and as officers of the court.[119]

In the memorandum, the lawyers stated that the RAF had developed a 'narrative' that blamed lawyers for the fund's problems and was 'intended to distract attention from ineptitude and negligence at the RAF'. The situation had become so bad that 'accident victims were prevented from lodging claims against the RAF'. In addition, the RAF failed to deal promptly with claims because it was 'largely dysfunctional, incapable of basic administration, and engaged in unnecessary litigation while failing to heed several court orders'. According to the memorandum, 'basic office administration did not happen' at the RAF. Instead, 'emails went unanswered, claims were unacknowledged, documents were mismanaged, and the helpline did not function'. [120]

The authors of the memorandum sought an urgent meeting with those responsible for the RAF. They also called for the appointment of a new board (the existing board's term of office had ended but no new appointments had yet been made), the appointment of a suitably qualified CEO, and the institution of 'business basics' – with phone calls answered, messages returned, and communications acknowledged. They also wanted the RAF to start respecting court orders and to pay claims and bills on time. A dedicated RAF court should also be established to help deal with claims, they added.[121]

The gross inefficiencies within the public service, key SOEs, the Compensation Fund, and the RAF provide some indication of the problems likely to arise within the NHI Fund. However, the inefficiencies at the NHI Fund will loom far larger. To begin with, the NHI Fund is likely to need at least R659bn at its start, which is very much more than the sums handled by the Compensation Fund and the RAF each year. In addition, these other two funds cater for relatively small groups of people, whereas the NHI Fund will have to control, and pay out on all the healthcare requirements of more than 60 million South Africans in every year.

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[118] https://www.businesslive.co.za/bd/national/2023-06-25-raf-board-must-go-says-scopa/

[119] https://www.businesslive.co.za/bd/national/2023-07-25-lawyers-denounce-largely-dysfunctional-raf/?utm

[120] https://www.businesslive.co.za/bd/national/2023-07-25-lawyers-denounce-largely-dysfunctional-raf/?utm

[121] https://www.businesslive.co.za/bd/national/2023-07-25-lawyers-denounce-largely-dysfunctional-raf/?utm

Complex payment and procurement processes

The NHI Bill makes it clear that the NHI Fund is to become 'the single purchaser and single payer of healthcare services' for all South Africans. [122] It will therefore have to purchase and pay for all the treatments provided by hospitals, clinics, specialists, GPs, nurses, dentists, opticians, physiotherapists, and other health professionals. It will also have to purchase and pay for all 'health goods' and 'health-related products', ranging from aspirin and antiretroviral medicines (ARVs) to rubber gloves, thermometers, stretchers, crutches, wheelchairs, prosthetics, dental drills, and x-ray machines (to name but a few examples).

Payments to health providers at levels above the primary one will generally be channelled to central, provincial, and district hospitals, which will then be responsible for paying the doctors and other practitioners working at these facilities. As for the payments needed at the primary level, these will generally be made via the proposed 'Contracting Units for Primary Health Care'. These contracting units will receive bulk sums from the NHI Fund and then disburse these further to GPs, pharmacists, physiotherapists, dentists, and the like.[123]

These bulk payments will help reduce the number of disbursements to health providers that need to be handled by the NHI Fund itself. The overall payment burden will nevertheless be considerable – especially as the Bill stresses that the payments made to health professionals must be based on the 'quality and value' of their services.[124] However, such 'quality' and 'value' are notoriously difficult to assess (see *Health Market Inquiry*, below). This requirement in itself could thus make for long delays in the payment of health professionals.

At present, the procurement of 'health goods' and 'health-related products' is split among many different entities, which helps reduce the burden on any one of them. Such entities include provincial health departments, medical schemes, private hospitals, pharmacies, and private GPs, to name but some examples. This decentralised and market-based system is efficient, adaptable to shifts in demand, and requires no centralised procurement plan. The situation will be very different under the NHI, however, when all procurement is to be carried out by the NHI Fund and its subsidiary entities.

The procurement process will start with the Health Products Procurement Unit (HPP unit). The HPP unit will set 'the parameters' for the procurement of all 'health-related products', defined (in clause 38 of the Bill) as including 'medicines, medical devices, and equipment'.[125] (This definition of health-related products is different from the definition of 'health products' in Clause 1, making for confusion as to what the Bill intends.)

The HPP unit will decide what products qualify for purchase and include these on a 'national health products list'. The HPP unit – in conjunction with the 'Benefits Advisory Committee',

[122] Clause 2(a), Bill; Clause 1, Bill
[123] Clauses 35(2) (3) and Clause 37, Bill
[124] Clause 10(1)(k), Bill; see also Clause 39(4), (6), Bill
[125] Clause 38 (1), (2), Bill

and perhaps also with help of the 'Benefits Design Unit' in the NHI Fund – will also decide on 'the Essential Medicines List' and 'the Essential Equipment List'. These three lists, together with an approved 'Supplier' list, will constitute the NHI's 'Formulary'.[126]

This Formulary will need to be approved by the health minister 'in consultation' with the NHI Fund and the National Health Council (a health policy advisory body established under the National Health Act of 2003). The Formulary will also have to be reviewed, amended, and re-approved at least once a year, so as to take account of 'changes in the burden of disease, product availability, price changes, and disease management'.[127]

This complex and time-consuming bureaucratic process will have to be implemented every year because the market mechanism will no longer be available to determine supply and demand. Instead, deployed cadres will decide on every single health product likely to be required by the country's population from one year to the next.

Quite how procurement will then proceed is difficult to tell. According to the Bill, 'an accredited health establishment' – say, a rural public clinic – must 'procure according to the Formulary and suppliers listed in the Formulary must deliver directly to that...health establishment'. The same rule will apply to 'an accredited health care service provider', such as a GP, pharmacist, dentist, or optician.[128]

However, the HPP unit must also be included in this procurement process, for part of its job is to 'support the process of ordering and distribution of health-related products' at both national and district levels. At the district level, the 'District Health Management Offices' to be established in every district municipality must also play a part, for these offices are supposed to 'conclude and manage contracts with suppliers and vendors' with the help of the HPP unit.[129] (Clause 1 defines a 'supplier' but the Bill contains no definition of a 'vendor'.)

What then of other relevant NHI Fund units, particularly the 'Purchasing and Contracting' unit and perhaps also the 'Health Products Procurement' unit? (It is unclear whether this latter unit is the same as the HPP unit envisaged in Clause 38. For, under Clause 20, all NHI units are to be established by the CEO of the NHI Fund, acting under the 'direction' of the Board. By contrast, under Clause 38, the HPP unit is to be established by the Board, 'after consultation with the minister').[130] How these two (or three) units are to interact with one another in the procurement process is not explained. But bureaucrats at national and district levels will be tripping over each other, it seems, both in the tendering process and in concluding contracts.

[126] Clause 38(4), Bill
[127] Clause 38(4),(5), Bill
[128] Clause 38(6), Bill
[129] Clause 38(3)(e) and (f), Bill
[130] Clause 20(3), Bill; cf Clause 38(1), Bill

What about services such as the maintenance of lifts or the repair of dialysis machines in both public and private hospitals? Clause 1 of the Bill now defines a 'supplier' as a 'natural or juristic person in the public or private sector providing goods and services other than personal health care services' – and this definition should be wide enough to cover maintenance and repair services. But the Bill's provisions on procurement deal expressly with 'health products', not maintenance and similar services. Hence, the maintenance procurement need has still not been adequately dealt with by the drafters of the Bill. In the absence of clear statutory authority for the procurement of such services, the maintenance and repair of necessary buildings and equipment will be impossible to carry out under the NHI's 'single purchaser' and 'single payer' system.

When it comes to paying approved suppliers, the Bill is even more confusing. The payment of suppliers is not a listed function of the HPP unit, so this task presumably falls instead to the 'Provider Payment Unit' within the NHI Fund.[131] Generally, however, the Bill defines 'providers' as the health professionals responsible for providing health treatments of various kinds. In addition, the definition of 'provider payment' in Clause 1 is clearly directed at the payment of doctors and other health professionals, who are to be paid for 'health care services' under a 'uniform reimbursement strategy'.[132] How then are the suppliers of health-related products to be paid? This issue has been omitted from the Bill, making it impossible for this function to be carried out on the present wording of the measure.

Let us assume, however, that the Bill is amended to include a 'Supplier Payment Unit' within the NHI Fund. Various challenges will still need to be resolved. In particular, how is this mooted Supplier Payment Unit to ensure that products of the correct quantity and quality have in fact been delivered to the tens of thousands of accredited health care establishments and service providers across the country that have ordered them from accredited suppliers? These contracts will have been concluded with the help of the HPP unit, the relevant District Health Management Office, and the Purchasing and Contracting unit within the NHI Fund Unit – but payments will nevertheless not be due unless and until delivery has taken place and all aspects of the relevant procurement agreements have been fulfilled.

How long will it take for the mooted Supplier Payment Unit to check on delivery and other aspects of performance and then make the payments it agrees are due? This is a particularly pertinent issue, given the number of contracts likely to be in place across the country and the state's notorious inability to pay many of its suppliers within 30 days.

At the end of March 2019, for instance, national and provincial departments owed suppliers more than R7.1bn on invoices more than 30 days old. By the end of June 2019, a scant three months later, provincial departments had racked up another R4.3bn in unpaid debts. Provincial health departments (except in the Western Cape) were the worst offenders, owing R5.8bn to suppliers in March 2019 and another R3.7bn three months later. The underlying

[131] Clauses 20(3)(g) and 38, Bill
[132] Clause 1, Bill

reason for late payments is not simply inefficiency, as the Public Service Commission (PSC) has pointed out. Rather, 'at the core of [non-payment] is corruption. "If you don't bribe me, I'm not going to pay"', as PSC director general Irene Mathenjwa told a parliamentary committee in November 2019.[133]

Often, moreover, the payments due are delayed for years, rather than months, and involve considerable amounts. As DA Gauteng Shadow Health MEC Jack Bloom has pointed out, in January 2023 almost a thousand companies (940) were owed an astounding R1.86bn by the Gauteng health department.[134] How many suppliers, particularly overseas ones, will stop supplying health establishments and health professionals working within the NHI system if payment is frequently delayed? How many local suppliers will go bankrupt while waiting for the NHI to pay?

More seriously still, how many people will die – or see their health deteriorate – if the medicines or other goods or services they need have not been paid for and cannot be obtained? Medicine and other 'stock-outs', already common in the public sector, will become common in private healthcare too. This will rob people of the efficient healthcare supplies that are currently available. It will also reduce access to healthcare, which is contrary to what Section 27 of the Constitution requires. These problems with the NHI's 'single-payer' model must be acknowledged, not brushed aside.

Problems with single-payer systems

International experience shows that single-payer systems are generally ineffectual – which is why few countries have them. Prime among these 'single-payer' states are Cuba and Canada. However, Cuba is very different from South Africa, for its population numbers some 11m and it pays its doctors a mere $720 a year (in 2012 figures). This puts its per capita health spend at roughly $2 475 a year, whereas South Africa – with its bigger population and far better paid doctors – has an annual per capita health spend of only $1 150. Cuba also 'traffics its doctors internationally for revenue', notes Michael Settas of the Free Market Foundation, which means it can hardly be considered 'an aspirational standard'.[135]

As regards Canada, Mr Settas adds, 'the woes of its health system are well documented: rising costs with deteriorating quality – the inevitable outcomes in any centrally-controlled and monopolised system'.[136] Yet the NHI is unlikely to match what even the flawed Canadian health system is able to provide. 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, as the administration of

[133] *Business Day* 4 September 2019; Leon Schreiber, 'Collapsing public service makes NHI impossible', *Politicsweb.co.za*, 13 October 2019; *Business Day* 7 November 2019

[134] https://www.news24.com/citypress/news/gauteng-health-department-struggles-to-pay-medical-suppliers-on-time-says-jack-bloom-20230223

[135] *Sunday Times* 8 September 2019, 'Single Payers of the World v South Africa', in Dr Johann Serfontein, Healthman Consultancy, 'National Health Insurance', Presentation to the Free Market Foundation, Johannesburg, 21 November 2019

[136] Ibid

its healthcare system is in fact divided among its ten provinces. Thirdly, 65% to 75% of Canadians have some form of supplementary health insurance,[137] which increases the treatment options available to them and spares the state-run system from having to meet every health need.[138]

Also relevant are the lessons from the United Kingdom (UK), which has shifted its National Health Service (NHS) from a single-payer model to a multi-payer one. In this revised model, 'providers and funders now compete for the business of the patient', as Mr Settas notes. This change has brought about 'improvements in outcomes, reductions in waiting times, and greater patient satisfaction'. These improved metrics, he adds, confirm that 'competing multi-payer systems, along with providers competing for funded patients, achieve superior outcomes at lower costs than single-payer models'.[139]

Even with this shift, moreover, NHS costs and outcomes compare poorly with those in other developed countries. In August 2023 waiting lists for NHS treatment in England reached almost 7.6 million, a record high. The number of patients waiting for treatment for more than a year dropped slightly, but nevertheless stood at a staggering 383 000.[140] Yet in 2022 the UK spent 11.3% of GDP on healthcare,[141] which is far more than South Africa can afford. In that year, the NHS also came second last among 19 developed countries for saving lives with 'treatable' illness, and third last as regards those with 'preventative' illness. 'No one seriously claims any more that the NHS is the "envy of the world"', commented an article in *The Spectator* in July 2023.[142]

According to Barry Childs, a healthcare actuary, no middle-income country uses a single-payer system. Having analysed the models used by Australia, Brazil, Canada, China, France, Ghana, Kenya, the Netherlands, Thailand, and the UK, Mr Childs points out that most of these countries in fact have multi-payer systems. Thailand, for example, has three state-run funds, while Germany has 124. In addition, most countries with universal health coverage have retained their medical schemes – which is very different from what South Africa plans to do.[143]

Writes Mr Childs: 'Private insurance exists meaningfully in almost every country, to cover services not provided by an NHI or its equivalent, to fund co-payments, to offer wider provider choice, including access to private providers, and to shorten waiting times'. Allowing this kind of choice is vital, he adds, because no system of universal health coverage

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[137] *Sunday Times* 8 September 2019; see also Wikipedia, Health Care in Canada, https://en.wikipedia.org/wiki/Healthcare_in_Canada
[138] Ibid
[139] Ibid
[140] https://www.spectator.co.uk/article/rishis-target-creeps-away-as-nhs-backlog-climbs/?
[141] https://www.spectator.co.uk/article/the-nhs-isnt-underfunded/
[142] https://www.spectator.co.uk/article/happy-birthday-nhs-heres-why-youre-not-feeling-too-good/?u
[143] *Sunday Times* 8 September 2019, 'Single Payers of the World v South Africa', in Dr Johann Serfontein, Healthman Consultancy, 'National Health Insurance', Presentation to the Free Market Foundation, Johannesburg, 21 November 2019

(UHC) can be comprehensive enough to meet all needs. Hence, 'in all UHC systems there are rationing committees – known by critics…as death committees – that decide what procedures and medication will be covered'. This kind of 'gatekeeping and rationing' is essential to stop costs spiralling out of control. But it also means that people must have choices beyond the state system if their healthcare needs are to be met.[144]

In South Africa, however, the government is so intent on eliminating choice that it not only wants to terminate medical schemes but also plans to prevent people from using their own money to consult private specialists outside the NHI system. This would be permitted, said Dr Mkhize in 2019, only 'if there was a compelling reason' for such a consultation. Added Dr Mkhize: 'It is not my right to see a specialist because I can afford it. It is a distortion of how the system should be working.' NHI bureaucrats will thus be intent on ensuring that the wealthy can no longer obtain better healthcare than the poor. However, as the *Financial Mail* commented, 'for the minister to begin dictating what medical care you can buy is a slippery slope… It would be outright tyrannical to vest responsibility for deciding who gets critical healthcare in the people least qualified to make that call: state bureaucrats'.[145]

BEE procurement requirements

The inefficiencies inherent in any single-payer model are sure to be compounded in South Africa by BEE requirements, which will further jeopardise cost-effective procurement. Under the Bill, all NHI purchase agreements will be subject to 'public procurement laws and policies', including the Preferential Procurement Policy Framework Act of 2000 or PPPFA (which is soon to be replaced by the Public Procurement Bill of 2023) and the Broad-Based Black Economic Empowerment Act of 2003.[146]

Under the PPPFA, BEE suppliers to state entities may charge more (10% on contracts worth R50m or over, 20% on contracts below this threshold) and still win tenders. In practice, however, the preferential pricing permitted is commonly far greater – with BEE 'tenderpreneurs' often charging between 100% and 300% more than standard prices. Sometimes the mark-up is still larger. In 2016, for instance, the Treasury lamented the price paid by the state for a paper binding machine (R27 500), saying this was 13 times higher than the norm.[147]

In 2009 Pravin Gordhan, then finance minister, told Parliament that one of the biggest problems confronting government was that it paid more for everything, from pencils to building materials, than a private business would: 'R40 million for a school that should have cost R15 million, R26 for a loaf of bread that should have cost R7'. In 2012 Gwede Mantashe, then ANC secretary general, also condemned inflated pricing, saying: 'This thing

[144] Ibid
[145] *Financial Mail* 1 August 2019
[146] Clause 38(7), Bill
[147] National Treasury, Preferential Procurement Regulations of 2016, effective 1 April 2017; *Bloomberg*, 6 October 2016

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.' Mr Mantashe urged BEE companies to 'stop using the state as their cash cow by providing poor quality goods at inflated prices'.[148]

However, as one BEE contractor told *The Star* in 2012, businessmen seeking contracts with the state have little choice but to charge inflated prices to 'recoup the costs of paying mandatory kick-backs' to corrupt officials and 'regularly donating huge sums' to the ANC and its allied organisations. Said the contractor: '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 upon 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 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.[149]

Though few other businessmen have admitted to making payments of this kind, the comment seems to provide an insight into a wider pattern of conduct. It is also consistent with Treasury warnings against the 'inflated prices and fraud' that taint between 30% and 40% of state tenders (see *Fraud and corruption*, above).

More recent examples of inflated pricing at Eskom show that the problem of inflated pricing has grown worse, rather than abated. As former Eskom CEO Andre de Ruyter relates in his book *Truth to Power: My Three Years Inside Eskom*, the parastatal confronts corruption in procurement on a staggering scale. According to a *mybroadband.co.za* report, citing his book: 'Eskom paid R26 for a single-ply toilet roll costing R5, a 420% mark-up; it paid R51 for a black refuse bag which retails for R2.99; it ordered a wooden mop for R280 000; and it paid R80 000 for knee pads which cost R150 at Builders Warehouse; while one knee pad supplier paid R4 025 and charged Eskom R934 950'.[150]

Against this background, it is very likely that NHI procurement, once it is made subject to BEE obligations, will increasingly become tainted by fraud and inflated pricing too. Yet the more the NHI Fund's procurement budget is wasted in this way – for the benefit of a relatively small and politically connected elite – the less money will be left available to meet the pressing healthcare needs of all South Africans.

Other challenges will also arise. Under the BEE Act and its generic codes of good practice, the target for preferential procurement is 80% of total annual purchases, of which half must come from 51% black-owned companies and another 12% from firms that are 30% black women-owned. But BEE firms with these levels of black ownership simply do not exist in

[148] *Business Day* 18 September, *Sunday Times* 20 September 2009
[149] *The Star* 22 August 2012
[150] https://mybroadband.co.za/news/investing/493591-eskom-paid-r934950-for-kneepads-and-r238000-for-a-mop-de-ruyter.html

sufficient number. The use of BEE 'middlemen' in NHI procurement is thus likely to become widespread. This will add to costs and further encourage corruption among the tens of thousands of bureaucrats responsible for administering the NHI behemoth.

The NHI will thus bring a BEE procurement bonanza to the political elite. This is doubtless a key (though unacknowledged) reason for the government's insistence that the NHI is the only way to achieve universal health coverage. Most ordinary South Africans, however, will find that the revenue that ought to be available for healthcare goods and services each year is much reduced by BEE procurement abuses. This will give them yet more reason to lament their forced reliance on the NHI's monopoly over healthcare.

Certification and accreditation for NHI participation

The initial version of the Bill made it clear that all health providers and facilities, whether public or private, that wished to participate in the NHI would first have to be assessed and certified by the Office of Health Standards Compliance (OHSC). Once OHSC certification was obtained, the Accreditation Unit of the NHI Fund would decide whether accreditation should follow.

These requirements remain much the same in the current version of the Bill, but with one important difference. Under the revised wording of Clause 39, the NHI Fund will be able to grant '*conditional accreditation* to a health service provider or health establishment, as prescribed by the minister after consultation' with the OHSC.[151]

It is easy to see what has prompted this amendment. Public hospitals and clinics are so bad at complying with minimum healthcare norms and standards – even on such basics as hygiene and the availability of medicines – that only some 20% would qualify for NHI accreditation on the original wording of the Bill. The remaining 80% would be barred from participation in the NHI. This would be extremely damaging, as it would greatly diminish the public healthcare resources available to millions of people just as demand for health services went sharply up.

Instead of trying to solve this problem by allowing conditional accreditation, the government should focus on rectifying the inefficiency, poor management, corruption, and lack of accountability that makes for poor performance at so many public healthcare facilities. By contrast, the Bill will allow badly managed public hospitals and clinics to participate in the NHI on the basis of a conditional accreditation process decided by the minister 'after' consulting the OHSC. This wording will allow the minister to disregard the OHSC's perspective. In addition, the Bill places no time limit on 'conditional' accreditation. Such accreditation could thus persist for many years, while problems needing urgently to be overcome remain unaddressed and unresolved.

[151] Clause 39(12), Bill, emphasis supplied by the IRR

In addition to OHSC accreditation, health professionals and health facilities will probably also need 'certificates of need' to qualify for NHI accreditation. The National Health Act of 2003 already provides for such certificates, but these provisions are not yet in force and would need to be made operative – assuming they survive a legal challenge to their constitutional validity.

Under the certificate-of-need provisions in the National Health Act, all health professionals will require such certificates from the Department of Health if they are to provide health services, open health establishments, or keep operating existing ones. In deciding whether to grant or refuse such certificates, the director general of health must assess 'the appropriate utilisation' and 'equitable distribution' of healthcare resources; whether 'existing public and private health services' adequately meet community needs, and 'whether a private health establishment is for profit or not'. More than ten criteria are listed and most are vaguely phrased, thereby infringing the constitutional requirement for clear and certain rules.[152]

In June 2022 Acting Judge Thembi Bokako, sitting in the high court in Pretoria, struck down the certificate-of-need clauses, finding that they were too vague to pass constitutional muster. In addition, they undermined the dignity of health professionals, overrode their choices on where to live and work, hindered their capacity to practise their profession, and eroded their property rights by allowing the state to close down their practices. They might also encourage health professionals to emigrate rather than move to underserviced areas. Yet this would reduce the health services available and conflict with the right to the 'progressive' expansion of health services under Section 27 of the Constitution.[153]

However, the Department of Health was absent from these court proceedings and later claimed not to have been properly served. In June 2023 Judge Brenda Neukircher ruled that the sheriff had indeed failed to serve the necessary documents on the Department – and so rescinded Judge Bokako's judgment. The matter must thus return to court for a further hearing at which the Department will be present.[154] Whether the certificate-of-need clauses will be struck down again remains uncertain.

If the certificate-of-need clauses are in fact upheld, the Department could in future insist that health professionals obtain certificates of need as a condition for NHI accreditation. The current Bill is less clear on this than its 2018 predecessor, but it still speaks of health providers having to be 'certified' under the National Health Act.[155] Health professionals not wanting to work with the NHI could also find themselves barred from practising at all unless they can obtain certificates of need.

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[152] https://dailyfriend.co.za/2023/06/23/half-wit-sheriff-resuscitates-certificates-of-need-for-doctors/

[153] https://dailyfriend.co.za/2023/06/23/half-wit-sheriff-resuscitates-certificates-of-need-for-doctors/; see also https://www.werksmans.com/legal-updates-and-opinions/gerrymandering-healthcare/

[154] https://www.businesslive.co.za/bd/national/health/2023-06-21-health-minister-to-get-his-day-in-court-to-defend-plans-to-control-where-doctors-work/

[155] Clause 10(1)(b), Bill

The certificate-of-need requirement will thus further cement the state's control over all doctors and other health providers. Health professionals wanting to retain their current practices in towns and suburbs may be told that they will qualify for certificates of need only if they are willing to work instead in under-serviced rural areas, townships, or informal settlements. Effectively, many doctors may thus have to move to under-serviced areas if they want to keep practising. However, doctors who are called upon to uproot themselves by moving from urban to rural areas might instead decide to leave the country altogether.[156]

In October 2019 an opinion poll carried out among health professionals for Solidarity, a civil society organisation, showed that 21% of respondents had already taken steps to emigrate, while a further 42% said they would consider emigrating when the NHI was implemented.[157] Since then, concern about the dangers inherent in the NHI have increased, as revealed by subsequent Solidarity surveys in 2021 and 2023. The 2023 survey shows that distrust of the NHI has grown to the point where 94% of respondents – drawn from diverse medical professions and demographic groups – believe that 'private health practitioners may decide to go and work abroad' because of it. In addition, 19% have already initiated the emigration process. [158]

Solidarity's findings are even more disturbing than those obtained by the South African Medical Association (SAMA) in 2021. SAMA's survey found that 38% of its members planned to emigrate because of the NHI, while another 17% were not sure if they wanted to leave.[159]

Many health professionals are also deeply concerned about the negative impact of the NHI on healthcare. The survey carried out by Solidarity in 2019, for instance, showed that 80% of the practitioners canvassed were sceptical about the NHI. Some 85% thought it could destabilise the healthcare system, while only 15% thought it would be possible to implement the NHI successfully. Moreover, when the *Financial Mail* tried to probe the views of other health professionals, Karin Morrow, a private GP in Durban, responded: 'There is an unease that the government will destroy all health care in its transparent bid to grab private healthcare users' money.' Added Jonathan Witt, an anaesthetist: 'It will be like Eskom, SAA and the SABC combined, except that many people will die.'[160]

Concerns among health providers have since deepened even more, as Solidarity's 2023 survey shows. According to this survey, '99% of respondents are deeply concerned about the

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[156] Serfontein, National Health Insurance, 'Presentation to the Free Market Foundation', 21 November 2019
[157] Solidarity, 'Report shows healthcare workers' huge concerns about NHI', *Politicsweb.co.za*, 30 October 2019
[158] https://www.politicsweb.co.za/politics/doctors-fiercely-opposed-to-nhi--solidarity
[159] https://businesstech.co.za/news/government/572964/south-africa-faces-exodus-of-doctors-and-other-professionals-because-of-the-nhi/
[160] Solidarity, 'Report shows healthcare workers' huge concerns about NHI', *Politicsweb.co.za*, 30 October 2019; *Financial Mail* 17 October 2019

government's ability to administer and manage the NHI', while '94% of respondents believe the successful implementation of the NHI is unlikely'. Corruption is a key concern, with most respondents sharing a 'consensus' view that the NHI will be 'a vehicle for government officials to enrich themselves'. In addition, many feel that 'it simply cannot work', since it lacks 'essential elements, such as funding, skilled staff, sound infrastructure, and expertise'.[161]

A host of unmet promises

Without the buoyant tax revenues, efficient procurement, and rising numbers of health professionals essential to its success, the NHI will fail to provide the health benefits the government is now promising. Unless the economy starts growing strongly, the country's already diminishing tax revenues will not keep pace with expanding demands for healthcare – or even with health inflation likely to average at least 5.5% a year. NHI benefits will thus have to be trimmed in each succeeding year so as to ensure, as the 2019 SEIAS report puts it, that 'overall expenditure does not exceed available resources'.[162]

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

The NHI and private healthcare

South Africa has a world-class system of private healthcare, to which some 32% of its population on average, or roughly 19 million people, have access through their medical schemes, health insurance policies, and/or out-of-pocket payments. In the 2021/22 financial year, spending on private health care amounted to about R260bn, of which R225bn went to medical schemes and the rest to out-of-pocket purchases and health insurance. South Africa's medical schemes thus play a vital part in providing access to private healthcare.[163]

The number of people belonging to medical schemes has risen from 6.9 million in 1997 to 8.9m in 2020, an increase of some 30%. However, because the population has grown faster, medical scheme membership as a proportion of the population has declined slightly, from roughly 16% in 1997 to 15% in 2020.[164] The demographic representation of medical schemes members has nevertheless changed substantially, for 49% of members are now black, while 10% are so-called 'coloureds', 7% are Indian, and the remaining 34% are white.[165] However,

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[161] https://www.politicsweb.co.za/politics/doctors-fiercely-opposed-to-nhi--solidarity

[162] Helanya Fourie, 'Unpacking health inflation in South Africa', *Econex Blog*, 16 August 2019, p2; SEIAS 2019 assessment, p39

[163] https://dailyfriend.co.za/2022/08/20/the-private-health-system-oh-so-expensive/?; https://www.medicalschemes.co.za/cms-annual-report-2021-22/; https://www.medicalschemes.co.za/the-medical-schemes-industry-in-2021/, pp26, 51

[164] CRA, *2023 Socio-Economic Survey of South Africa*, p481

[165] 2018 *South Africa Survey*, p625; Council for Medical Schemes, *Annual Report 2016/2017*, p130; 'Medical aid coverage by population group and sex', Table 4.2, in Statistics South Africa, *General Household Survey,*

most black South Africans cannot afford the rising costs of medical aid, so only 9% of the total black populations had medical scheme membership in 2021.[166]

Even though medical scheme membership has risen strongly among the black middle class, the government nevertheless plans to use the NHI to put an end to almost all medical schemes. Various provisions in the NHI Bill will help bring this about.

First, many people will battle to afford both their medical scheme contributions and the NHI 'mandatory prepayments'[167] they will be compelled to make. Second, additional taxes will be levied to help fund the NHI, while the medical scheme tax credit will be removed. Third, medical schemes will be confined to offering 'complementary' cover for services 'not reimbursable by the Fund'.[168] Restricting medical schemes in this way will further sound their death knell. A scheme could still cover a rare disease such as haemophilia (uncontrollable bleeding), if this was excluded from the NHI package. But the pool of potential members wanting cover of this kind would be very small. Monthly contributions would thus have to be set so high that only the very rich could afford them. Few medical schemes are likely to survive these regulatory blows.[169]

Former health minister Dr Aaron Motsoaledi was adamant that all medical schemes would 'eventually be gone', once the NHI was fully in operation – and Dr Phaahla has since confirmed this view. In the interim, the government is seeking to reduce the number of medical schemes via 'consolidation': in other words, by encouraging or requiring small schemes to join up with bigger ones. However, once the NHI had been rolled out, the medical schemes that remain, as Dr Motsoaledi said in 2017, will 'all be collapsed into a single state-run medical aid plan': the NHI Fund.[170]

At the same time, the NHI 'war room' in the presidency has scotched any notion that medical schemes, with their accumulated experience and expertise, may be permitted to help administer the NHI Fund. According to Aquina Thulare, who works in the war room, the NHI Fund will be administered by the state alone and its functions are 'not going to be outsourced'.[171]

Making private healthcare more costly to access

For the past 20 years, the government has been moving towards its ultimate goal of eliminating medical schemes by pushing up membership costs while declining to introduce

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2016, P0318, Alex van den Heever, 'Is it about transformation or patronage?' *Daily Maverick*, 27 August 2019; see also Council for Medical Schemes, 'Presentation to the Portfolio Committee on Health', 29 August 2019

[166] Dr Chris Archer, NHI Commentary, Presentation to the Free Market Foundation, 20 April 2016; statista.com/statistics/1115752/share-of-medical-aid-scheme-members-in-south-africa-by-population-group/.

[167] 2017 White Paper, para 305; Clauses 1, 2, 57(5), Bill

[168] Clause 33, Bill

[169] Johann Serfontein, Briefing to the Free Market Foundation, 20 April 2016

[170] *Business Day* 15 May, *The Times* 11 May 2017; https://www.businesslive.co.za/bd/national/health/2022-11-17-state-will-press-ahead-with-nhi-regardless-of-state-of-economy-phaahla-says/

[171] *Business Day* 8 August 2019

measures that would help to bring these costs down again. It has also taken various other steps to exclude more affordable means of accessing private sector care.

Over these two decades, the government has thus:

- introduced an arbitrary reserve requirement (25% of annual contributions) which is unnecessarily high for many medical schemes;[172]
- insisted on open enrolment and community rating, which requires the young and healthy to pay more than they otherwise would and deters them from joining medical schemes;[173]
- insisted that all medical schemes 'pay in full' for some 300 'prescribed minimum benefits' (PMBs), irrespective of whether members want this cover;[174]
- reduced the tax benefits which help make medical scheme membership more affordable, while pledging to eliminate the remaining tax credits altogether over time;[175]
- resolved to end the government subsidy which helps public servants pay their medical scheme contributions;[176]
- barred the introduction (earlier planned for January 2016) of low-cost medical schemes, which could have made membership available to a further 15 million people at premiums averaging R200 per adult member per month. These low-cost schemes have still not been permitted to start operating because the ANC regards them as 'a stumbling block on the path' to the NHI;[177]
- introduced regulations that aim to put an end to the primary health insurance policies on which some 2 million people currently rely to access private healthcare from GPs and others, also at a cost of some R200 a month.[178]

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[172] Jasson Urbach, 'Paying for Intervention! How statutory intervention harms South African health care', Health Policy Unit, Free Market Foundation, 2009, p20-21; *Saturday Star* 15 October 2016, *Business Report* 27 October 2017

[173] *The Times* 6 February 2015; Urbach, 'Paying for Intervention!' pp16-17; https://dailyfriend.co.za/2022/08/20/the-private-health-system-oh-so-expensive/?

[174] *Sunday Times* 23 July 2017, *Business Day* 23 July 2015; https://www.businesslive.co.za/bd/companies/healthcare/2021-10-03-medical-aid-schemes-blame-laws-for-barring-cheaper-health-cover/; https://dailyfriend.co.za/2022/08/20/the-private-health-system-oh-so-expensive/?

[175] *Mail & Guardian* 30 June 2017, *The Times* 28 August 2017; 'Media Release: Removing medical tax credits is yet another blow for tax payers', Free Market Foundation, 24 October 2017; *Business Day* 15 May 2017, *Business Day* 18 May 2017, *Mail & Guardian* 30 June 2017, *Business Day* 13 July 2017, *The Times* 28 August 2017; see also Dr Paula Armstrong, 'Medical Scheme Tax Credits and Affordability', Econex, *Research Note 46*, August 2017; *Business Day* 25 October 2017; https://dailyfriend.co.za/2022/02/16/next-step-towards-nhi-certificate-of-need-for-doctors/

[176] 2017 White Paper, para 308; *The Star* 7 March, *Business Day* 15 May 2017, *Mail & Guardian* 30 June 2017, *Business Day* 13 July 2017, *Business Day* 18 May 2017, *The Herald* 20 September, *Legalbrief* 21 September 2017

[177] *Business Day* 15, 16 October 2015; https://www.businesslive.co.za/bd/companies/healthcare/2021-10-03-medical-aid-schemes-blame-laws-for-barring-cheaper-health-cover/; https://www.businesslive.co.za/bd/national/health/2022-09-15-medical-aid-for-as-little-as-r130-a-month/

[178] *City Press* 15 January, *Business Day* 17 March 2017, *Money Marketing* 31 March 2017, *Business Day* 18 January 2017, *Sunday Times* 23 July 2017, National Treasury, Media Statement, 'Health Insurance Policies to Complement Medical Schemes through an Enabling Regulatory Framework, Release of Final Demarcation Regulations', 23 December 2017; *Business Day* 12 January, 24 January 2017, *Moneyweb* 21 February 2017;

Stigmatising private healthcare

The ANC is ideologically hostile to business and has long demonstrated a deep suspicion of the 'profit' motive in private healthcare. Both for this reason – and to help pave the way for its damaging regulatory interventions – it has repeatedly stigmatised the private healthcare system as costly, selfish, and uncaring in its constant drive to put 'profits before people'. The ruling party takes the view (to cite the words of Dr Manto Tshabalala-Msimang, minister of health in both Thabo Mbeki administrations) that the private health care system is little more than 'a ravenous monster that preys on our people'.[179]

Dr Motsoaledi also seemed driven by an ideological fervour against the private healthcare sector, which he repeatedly castigated as intent on profiteering and extortion. In 2011, for instance, Dr Motsoaledi lashed out at the private healthcare system, blaming it for poor healthcare 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, his best advice to anyone who yearned to be a billionaire was 'not to own a mine but a private hospital'.[180]

Also in 2011, Dr Motsoaledi described private healthcare as 'a predatory…system where the sick and the vulnerable are the ones who get attacked.' In 2012 he condemned the 'rampant commercialisation' of healthcare. He also blamed rising costs on the excessive fees supposedly charged by private hospitals and the deliberate 'over-provision' of medical services. He poured scorn on the suggestion that prices were increasing because medical scheme members were getting older and the newest treatment methods were often more expensive. Instead, he continued to claim that the main cause of medical inflation was 'private-sector greed' and described the mere 'existence' of medical schemes 'as a punishment for poor people'.[181]

In 2010 Dr Motsoaledi suggested that the Competition Commission should investigate high prices in private healthcare and the reasons for them. The minister made it clear that he wanted the Commission not merely to investigate costs, but also to 'regulate prices in the private healthcare sector'.[182] In response to this call, the Commission launched a comprehensive Health Market Inquiry (HMI). This began in 2014 and culminated in

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Dr Wilmot James, letter to the editor, *Business Day* 12 January 2017; Wilmot James, 'DA demands assessment of ban on private health insurance', *Politicsweb*, 10 January 2017; *Saturday Star* 10 June 2017, *Moneyweb* 14 March, *The Citizen* 15 March 2017, *Money Marketing* 31 January 2017, *Sunday Times* 20 August 2017, *Business Day* 23 January 2017; https://www.businesslive.co.za/bd/national/health/2022-04-11-news-analysis-hospital-insurance-policies-thrive-despite-regulatory-impasse/; https://www.businesslive.co.za/bd/national/health/2022-01-26-reprieve-for-inexpensive-health-insurance-products/

[179] Anthea Jeffery, 'The NHI Proposal: Risking lives for no good reason', IRR, *@Liberty*, Issue 29, December 2016, p50

[180] *Saturday Star* 23 July 2011

[181] *The Times* 26 January 2016, *The Citizen* 12 December 2015, 11 May 2016

[182] *The New Age* 23 November 2015, *Business Day* 19 May 2010

September 2019 with the publication (a scant ten days before written submissions on the NHI Bill were initially due) of a final report on the abuses it claimed to have uncovered.

Findings of the Health Market Inquiry (HMI)

According to the final HMI report, the private healthcare sector is 'neither efficient nor competitive'. Instead, the industry is 'highly concentrated, with disempowered and uninformed consumers, a general absence of value-based purchasing, practitioners who are subject to little regulation, and failures of accountability at many levels'. It is also characterised by 'high and rising costs of healthcare and medical scheme cover, and significant over-utilisation of services, with no evidence of improved health outcomes'.[183]

The report found that three major hospital groups (Netcare, Mediclinic, and Life Healthcare) together controlled more than 90% of the market, based on their registered beds and admissions in 2016. This level of concentration opened the way to 'collusion' and to 'consistently significant profits'. Over-concentration also 'made it very hard for newcomers and fringe-players to grow'. Hence, the three groups could 'all but dictate' year-on-year price increases for medical schemes.[184]

A similar pattern was evident among medical schemes, the report went on, for the number of schemes had almost halved from the 163 schemes in operation in 2000 to the 81 still in existence in 2017. Among open schemes, Discovery Health had a market share of 56% in 2017 (up from 35% in 2005), while the next-largest scheme, Bonitas, had a market share of 15% in 2017 (up from 10% in 2005). The other 19 open schemes all had less than 6% market share. In this environment, Discovery made profits that were 'multiples' of its competitors.[185]

These problems in private healthcare, the report continued, had been made worse by 'inadequate stewardship' by the Department of Health, which had not adequately used its 'existing legislated powers' to hold 'regulators to account'. In particular, the government had failed to use its full powers under the National Health Act of 2003 as regards both the licensing of facilities and the publication of 'a national database on...[the] pricing of healthcare goods and services'.[186]

The HMI report has been praised by many commentators, but is nevertheless deeply flawed in various ways. As regards private hospitals, for example, it declines to look at post-2016 data and so exaggerates the level of concentration in the sector. On registered beds, for example, the report identifies the market share of the key hospital groups as 27% for Life Healthcare, 26% for Mediclinic, 31% for Netcare, 13% for the National Hospital Network (NHN), and 3% for Independent hospitals. On this basis, it puts the Herfindahl-Hirschman

[183] Health Market Inquiry, *Executive Summary*, in *Final Findings and Recommendations Report*, 30 September 2019, pp30, 210; *Business Day* 3 October 2019, *Mail & Guardian* 4 October 2019, *City Press* 6 October 2019
[184] *HMI Report*, p185; *Executive Summary*, p31; *City Press* 6 October 2019, *Business Day* 2 October 2019, *businesstech.co.za*, 343626, 30 September 2019
[185] *Business Day* 2 October 2019
[186] HMI, *Executive Summary*, p30; *Financial Mail* 3 October 2019; *HMI Report*, p49; *Affluence* 5 October 2019

Index (HHI) – a standard measure of concentration developed for the far bigger US economy and not necessarily suited to South Africa – at 2 545 for registered beds. Since this score is above the 2 500 level, it indicates a 'high' level of concentration, the report concludes.[187]

However, the figures cited in the report seem outdated and misleading. If data from 2017 is taken into account, it shows that the National Hospital Network (NHN) has 25% of registered beds and that Independent hospitals have 9%, putting their combined total at 34%. This contradicts the HMI's conclusion that the NHN and the Independent group have only 16% of registered beds between them. It also shows that these newcomers have been able to expand significantly in recent years, which contradicts the report's claims to the contrary. In addition, the updated data yields a lower HHI score of 2 183, rather than the 2 545 stated in the report. This updated HHI score is well within the 'moderate' range (1 500 to 2 500), while the trend over time is one of 'declining concentration', as the Econex consultancy points out.[188]

There is also little evidence of the over-pricing the HMI report claims to have found. According to Compass Lexecon, also a consultancy, the HMI's own experts agree that hospital tariff increases have long been in line with inflation. In addition, the inquiry failed to uncover any proof of excessive pricing or profitability within private hospitals. This is largely because medical schemes in fact have considerable bargaining power in relation to hospital groups. In practice, moreover, hospital groups compete with one another to be included in the designated service provider (DSP) networks of different schemes and often 'materially' lower their tariffs in order to achieve this. In addition, schemes generally require prior authorisation for hospital admissions, a 'market-based solution' which has reduced any impetus towards unnecessary hospitalisation.[189]

The report's conclusions on medical schemes are also flawed. The report overlooks the extent to which the government's own regulations have pushed up the costs of medical scheme membership (as earlier outlined) and reduced the number of schemes, in keeping with the state's 'consolidation' goal. The report's implicit accusation that medical schemes are enriching themselves at the expense of their members is also difficult to reconcile with the figures on their profits, as released by the Council for Medical Schemes in October 2019. This report shows that there were 79 schemes at the end of 2018, which together received R174bn in risk contribution income (excluding monies paid into medical savings accounts) and cumulatively reported a net operating surplus of R1.2bn during 2018.[190] That figure, spread among 79 schemes, is hardly indicative of excessive profiteering.

Declining membership numbers in a difficult economic environment have also given remaining medical schemes strong incentives to compete with one another on cost and innovation in order to retain their existing members and attract as many new members as

[187] *HMI Report*, p72; *City Press* 6 October 2019
[188] Compass Lexecon, Presentation to Health Market Inquiry, 9 April 2019; Econex, Presentation to Health Market Inquiry, 9 April 2019
[189] Compass Lexecon, Presentation, ibid
[190] *Business Day* 4 October 2019

possible. Open schemes, in particular, thus seek to limit their annual increases, make their benefit options more attractive, and find innovative ways to attract the young and healthy.[191]

Having reached a number of contentious conclusions without adequate evidence, the HMI report goes on to make several recommendations that seem particularly helpful to the NHI. Among other things, it suggests:

- price controls for health professionals, to be achieved through a Supply-Side Regulator for Healthcare (SSRH), which will set the 'maximum' tariff increases to be allowed in subsequent negotiations over fees between medical schemes and practitioners;[192]
- additional controls on the licensing of private hospitals, so as to prevent 'an influx of beds not matched by needs' and promote 'diversity of ownership';[193]
- the mandatory reporting of health outcomes by doctors and other practitioners, so as to measure 'how treatments have improved patient health' (though such improvements often depend on people's discipline in taking medicines, for example, rather than the competence of doctors);[194] and
- an obligation on all medical schemes to provide 'a single, standardised and basic benefit package', which goes beyond the current prescribed minimum benefits (PMBs) to include primary care (visits to GPs), preventive care (vaccinations), and 'a list of specific items (medicines and devices) that must always be covered'.[195]

The Health Market Inquiry seems well aware that its report will be helpful to the NHI. It claims, for example, that 'fixing what drove up costs in the private sector is a necessary step towards successful NHI implementation'. It also acknowledges that many of its recommendations are in line with what the NHI proposes. The compulsory basic option it wants all medical schemes to provide is in keeping with 'social solidarity', it says, and will ensure that 'comprehensive quality healthcare services are available to all members irrespective of their income status'.[196]

The Department of Health has predictably seized on the HMI report to buttress its flawed arguments for the introduction of the NHI. As Dr Phaahla puts it, the department plans to use the report 'in its messaging around the NHI on why "things cannot stay the same"' in the private health sector. Dr Dhlomo, then chairperson of the portfolio committee on health, was also quick to take up this narrative. Said Dr Dhlomo at a press briefing in late October 2019: 'We are very excited and happy with the Health Market Inquiry report that has actually given us a story that says it is not only public health that has a challenge but even private health. So we want to move away from the story that says, fix your public hospitals and everything will

[191] *Business Day* 3 October 2019
[192] *Business Day* 3 October 2019; *HMI Report*, p181
[193] *HMI Report*, pp215-219, 101
[194] Ibid, pp198-208; John Kane-Berman, 'Report health outcomes or lose your doctor's licence', *Politicsweb.co.za*, 6 October 2019
[195] *HMI Report*, p110; *Business Times* 6 October 2019
[196] *City Press* 6 October 2019; *HMI Report*, p111

be OK. That story can't hold any more… We also have to fix what is taking place within the private healthcare sector.'[197]

According to Nehawu, the HMI report has unveiled 'a shocking state of affairs in the much-vaunted private health industry'. Private healthcare has been shown to be characterised by 'wide-scale profiteering' by 'the three giant monopoly hospital groups', by supposedly 'non-profit' medical schemes, and even by GPs and specialists who commonly subject their patients to 'financially catastrophic treatment procedures when more affordable and clinically effective modalities are available'. The trade union is thus planning an 'NHI mass education and mobilisation programme' to help 'fight against the widespread profiteering in the private health industry'.[198]

The SACP also welcomed the release of the HMI report, saying it 'puts to shame those opposed to the introduction of the NHI'. Added the party: 'At the centre of those opposed to the introduction of the NHI are private profit interests involved in the exploitation of the healthcare needs of the people for self-enrichment.' According to, the SACP, this means that the NHI is urgently required to bring about 'a radical reduction in the cost of healthcare', 'make it fair and affordable to patients', and protect scarce resources against 'looting by private profit interests'.[199]

By contrast, the Freedom Front Plus warned that the government was using the HMI report as a convenient 'stick with which to beat the private healthcare sector in an attempt to justify the implementation of the NHI'. The report was also being used to distract attention from all the problems in the public healthcare sector, which had effectively 'collapsed'.[200]

Ramifications of the NHI Bill

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

Implicitly, the government is promising that more than 60 million South Africans will soon be able to access the country's world-class private healthcare sector via its new state-controlled NHI system. It also assumes that the NHI will be adequately funded through the mandatory prepayments of the relatively few taxpayers with the capacity to contribute significantly. And it further presumes that this additional revenue, coupled with the additional resources the private healthcare sector can supply, will greatly reduce the pressure on public healthcare and thereby increase its efficiency.

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[197] *City Press* 6 October 2019; 'Dr Sibongiseni Dhlomo calls on public to get involved', *Daily Maverick* 30 October 2019

[198] Nehawu, 'Healthcare is a right and not a commodity', *Politicsweb.co.za*, 7 October 2019

[199] SACP, 'Release of Health Market Inquiry report welcomed', *Politicsweb.co.za*, 1 October 2019

[200] FF Plus, 'Govt using private healthcare report to justify NHI', *Politicisweb.co.za*, 2 October 2019

However, these assumptions are as false as the beguiling promises currently being made in support of the NHI. In practice, the NHI will fail to live up to these promises and will leave tens of millions of South Africans in the lurch.

People will be able to register for the NHI with the GPs or other primary providers of their choice – though only if their preferred practitioners are granted 'certificates of need' to practise nearby, or if their local public clinics qualify (perhaps conditionally) for accreditation by the OHSC. However, the demand for 'free' NHI services will be so enormous that all participating clinics, GPs, and other primary providers will inevitably have very long lists (or very long queues) of people waiting to see them. Waiting times could easily triple (as they have in Canada), and relatively few patients will be treated when they need this most.

Above the primary level, moreover, the NHI referral process will kick in – and people will have little choice as to the specialists or hospitals to which they are sent. If Dr Mkhize's view prevails, they will be barred from consulting the specialists that they prefer, even if they propose paying for this out of their own pockets. They will also find themselves cut off from a host of treatments, medicines, diagnostic tests, and other interventions if bureaucrats decide that these are either unnecessary or too costly. The cost barrier will worsen, moreover, each time the rand depreciates.[201]

Under the NHI, people will find themselves deprived of choice and entirely dependent on a state-controlled monopoly. The government will decide on all aspects of healthcare: from the benefits to be provided to the fees to be paid to doctors and other providers, the medicines to be prescribed, the blood tests to be allowed, the medical equipment to be used, the new health technologies to be permitted, and the recommended prices to be paid for every item, from aspirins and ARVs to sutures and cat scanners.

The government claims that these pervasive state controls will be effective in cutting costs and enhancing quality. But the large bureaucracy needed to implement them will be very costly in itself. Pervasive regulation will also stifle innovation, reduce efficiency, and promote corruption. So too will the BEE procurement rules to which every contract for health goods and services will be subject.

The country's 75 remaining medical schemes,[202] which are crucial in maintaining an independent private system outside of state control, will be pushed out of operation over time. The government has long been adamant (as Dr Motsoaledi has put it) that all medical schemes will 'eventually be gone', once the NHI becomes fully operative. What this means in practice is that the schemes which currently provide people with many benefit options and a

[201] *Financial Mail* 1 August 2019; Clauses 4(4), 5, Bill; Clauses 1, 7, 39, Bill
[202] https://www.medicalschemes.co.za/the-medical-schemes-industry-in-2021/

large degree of choice will in time 'all be collapsed'. People will then be left with only a single option on which to rely: the 'state-run medical aid plan' or NHI Fund.

South Africa's excellent private healthcare system will effectively be nationalised. The government will not take over the ownership of private hospitals and private practices, which will remain in the hands of their present owners, as Dr Mkhize earlier pointed out.[203] However, there is more than one way in which nationalisation can be carried out.

Under the NHI, this will be done via regulatory expropriation: by subjecting private healthcare to the state's comprehensive price and other controls, and by giving the NHI Fund the sole capacity to purchase and pay for all health goods and services. These interventions will give the government a stranglehold over all private hospitals and practices and their capacity to survive from one year to the next. They will also give the state complete control over the provisions, costs, and content of health services in the country. This government monopoly over health is likely to be just as ineffective and corrupt as the state's monopoly over the failing electricity system, the collapsing rail network, and the country's deteriorating ports.

The NHI's beguiling promises will inevitably prove false. Though steep 'NHI' tax increases will be introduced, supposedly to fund the new system, only a portion of those additional revenues will in fact be used for the NHI. The rest will be siphoned off to pay the public service wage bill or to bail out bankrupt SOEs. Moreover, even if all the additional revenues collected were to be ring-fenced for NHI purposes, the NHI Fund would still lack the financial and human resources required to meet the scale of need.

South Africa, with its high unemployment rate and small tax base, simply cannot afford the NHI proposal. The NHI will also be so ineffective and corrupt that its failures will help drive out the skilled middle class that currently pays the great bulk of the country's taxes. Many healthcare practitioners will emigrate too, rather than subject themselves to the state's comprehensive controls and persistent corruption and inefficiencies. The capacity of the NHI will thus be limited from the start – and will inevitably decline over time as resources shrink. Benefits will be reduced, while waiting times for treatment will lengthen to many weeks, months, and often years.

People will seldom get speedy help when they need it most: when children fall ill, or breadwinners are injured, or babies need to be delivered, or the elderly have strokes, or the chronically ill require their monthly medication. But the treatment choices which currently exist will have been removed – and South Africans will find they have no option but to rely on the state's single medical aid, irrespective of how badly it functions.

The real reason for the NHI proposal

[203] *Business Day* 28 August 2019

The ANC is ideologically hostile to business and has long demonstrated a deep suspicion of the 'profit' motive in private healthcare. Both for this reason – and to help pave the way for its damaging regulatory interventions – it has repeatedly stigmatised the private healthcare system as costly, selfish, and uncaring in its constant drive to put 'profits before people'.

Behind this constant denigration of private healthcare lies the ANC's commitment to the national democratic revolution (NDR): a strategy developed by the Soviet Union in the 1950s to take newly independent colonies by slow and incremental steps from capitalism to socialism (and ultimately to communism). In 1969 the ANC endorsed Moscow's idea that South Africa was 'a colony of a special type' – in which whites were the colonial oppressors and blacks their exploited subjects – and embraced the NDR. Though more than 50 years have passed since then, the ANC regularly recommits itself to the NDR, as it did once again at its Nasrec national conferences in December 2017 and again in 2022.[204]

The real aim of the NHI is not to improve healthcare but rather to advance the NDR by:

- moving closer to a 'socialised' economy, in which 'social needs' take precedence over 'private profits';[205]
- ensuring the 'decommodification' of healthcare, so that its 'availability and price is [no longer] determined by a profit-maximising capitalist market'[206] but is rather decided by the state;
- bringing about the uncompensated 'regulatory' expropriation of private hospitals, clinics, and other practices through laws that incrementally deprive their owners of the normal powers and benefits of ownership and may in time push them into bankruptcy;
- building dependency on the state for the fulfilment of a vital need; and
- establishing the principle that private spending must be pooled with public revenues for the benefit of those in need and in the interests of social solidarity.[207]

All these objectives are vital to the NDR, but the goals of 'decommodifying' healthcare and pooling private with public monies are particularly important. The 'decommodification' idea – which aims at giving the state control over the provision and pricing of key services – is supposed to extend in time from healthcare to education, social security, transport, housing, the environment, and work itself. The 'pooling' concept, once established in the context of the NHI, is also intended to move to other spheres. This process is likely to start in the pensions area, where proposals for the pooling of private and public contributions in a government-controlled 'national social security fund' have already been put forward.[208]

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[204] *Strategy and Tactics of the African National Congress, as adopted by the 54th National Conference 2017* (2017 S&T document); https://www.sabcnews.com/sabcnews/2nd-leg-of-ancs-national-conference-focuses-on-policies-addressing-social-economic-challenges/

[205] SACP, *The South African Road to Socialism, 2012-2017*, p11

[206] Ibid, p51

[207] www.iol.co.za, 15 August 2019

[208] Department of Social Development, Green Paper on Comprehensive Social Security and Retirement Reform, *Government Gazette*, no 45006, 18 August 2021; see also Nasrec *Strategy & Tactics* document, 2017, para 2.2.2

Dr Motsoaledi was thus correct in saying (in June 2018) that the NHI is 'the equivalent of "the land question" in health'.[209] However, there is no need for regulatory expropriation without compensation (EWC) in the health sector when incremental reforms can readily expand and improve the universal health coverage already available to all South Africans.

Alternatives to the NHI proposal

Both the current health minister and his predecessors have accused critics of the NHI of wanting to retain an unfair system and deprive South Africans of the benefits of universal health coverage (UHC). This accusation is false. It is not the UHC goal that critics oppose, but rather the inability of the NHI to achieve it. Critics also point to the folly of insisting on the NHI as the only way to proceed when better alternatives are readily available.

The World Health Organization on universal health coverage

As the ANC has often pointed out, the World Health Organization (WHO) is 'encouraging' countries to move towards 'universal health coverage' (UHC). This is also one of the Sustainable Development Goals the WHO hopes to see achieved by 2030.

According to the WHO, universal health coverage is intended to ensure that all people have access to the health services they need. These services should also be 'of sufficient quality to be effective' and should 'not expose their users to financial hardship'.[210] At the same time, the WHO does not prescribe to member states how universal health coverage is to be achieved. It recommends that countries should find ways to 'pool funds' and so 'spread the financial risks of illness across the population' in order to avoid crippling costs for both the poor and the rich.

The WHO also stresses that nations must choose the systems which suit them best – and that whatever option is adopted must be affordable in the long term. In addition, it categorically states that '*universal health coverage 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*'.[211] The NHI system, as envisaged in the NHI Bill, thus goes far beyond what the WHO envisages or recommends.

Achieving an effective system of universal health coverage

In devising a better mechanism for universal health coverage, the first aim must be to develop a system that is workable, financially sustainable, and in keeping with the recommendations of the WHO. Such a system must aim to preserve South Africa's private healthcare system, while giving all South Africans access to its benefits. It must also seek to improve efficiency

[209] *businesslive.co.za* 20 June 2018
[210] World Health Organization, Sustainable Development Goals, SDG 3.7; NHI Draft White Paper, 2015, para 48, note 5
[211] South African Private Practitioners' Forum (SAPPF), Submission on NHI Financing to the Davis Tax Committee, 12 October 2016, para 43, emphasis supplied

within the public healthcare sector and ensure that the country gets much more ‘bang’ for its already extensive healthcare ‘buck’.

In addition, a new system aimed at universal health coverage must seek to expand the supply of health professionals and health facilities. It must also find innovative and creative ways to extend the reach of limited resources. At the same time, it should not allow the rationing of health services by price to be replaced by the rationing of healthcare by waiting time, as this is no advance at all. A new system of universal health coverage must also avoid the effective nationalisation of private healthcare and be in keeping with the Constitution.

The IRR has thus developed an alternative model for universal health coverage, based on the following core ideas:

1.1 Open enrolment, community rating, and compulsory cover for some 300 prescribed minimum benefits (PMBs) have resulted in most medical scheme members paying monthly contributions that far exceed the actuarial risk they pose and their own health needs. Risk rating should be re-introduced to bring down premiums for the great majority, while schemes should no longer be obliged to cover all PMBs;

1.2 Special solutions will have to be found for those who are already old or ill when risk rating is re-introduced. One option for those with jobs 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). A tax-funded voucher might also be required to make these risk-rated premiums affordable to the old or ill. In addition, the government could introduce a basic health insurance scheme, administered by the private sector, to which all employees would contribute. Like the MediFund Life programme in Singapore, this would help pay for large hospital bills and various costly outpatient treatments, such as renal dialysis, chemotherapy for cancer, and antiretroviral treatment for those living with HIV/AIDS.[212]

1.3 All medical schemes should include ‘health savings accounts’ (HSAs), into which members pay a portion of their monthly contributions and which they own and control. In the United States, where HSAs are common, doctors and other health providers competing for the custom of patients with HSAs have found many innovative ways to improve delivery and hold down costs. These include mail-order pharmacies and walk-in (‘minute’) clinics in shopping malls;

1.4 Low-cost medical schemes should be introduced for those in formal employment who earn below the personal income tax threshold (currently some R19 750 a month).[213]

[212] Anthea Jeffery, ‘The NHI Proposal: Risking Lives for No Good Reason’, *@Liberty*, IRR, Issue 6, 2016, pp55-57, 66-69
[213] CRA, Public Finance, August 2023, p10

PMBs would not be covered, but members would be entitled to hospital benefits and would receive a minimum package of primary services (including a specified number of GP consultations, certain acute and chronic medication benefits, and basic radiology, dentistry, pathology, and optometry). Employees would pay a third of the monthly premium, while employers would pay the balance and receive an equivalent tax credit, along with points on a voluntary new 'Economic Empowerment for the Disadvantaged' or 'EED' scorecard;

1.5 Medical scheme membership should be made compulsory for all those in formal employment (with low-cost options and subsidised contributions available to those earning below the personal income tax threshold). On this basis, the number of medical scheme members would expand significantly – and medical scheme contributions could be reduced by between 20% and 35%, according to actuarial calculations, which would make membership still more affordable;

1.6 Low-cost primary health insurance products should be retained, not phased out. These policies, in return for reasonable and risk-rated monthly premiums, would also entitle people to a minimum package of primary services. This insurance option would be even more affordable, while employers could again be asked to contribute two-thirds of the monthly premiums payable by their employees in return for a tax credit and voluntary EED points;

1.7 Gap insurance policies and hospital cash plans should be retained, without the restrictions on cover that have been introduced in recent years, and would safeguard people from major in-hospital expenses;

1.8 State-funded health vouchers should be introduced for the 11.9 million South Africans who are unemployed (on the expanded definition) and the 4.8 million people who currently receive old-age pension or disability grants.[214] (Children under 18 would generally be included via their parents' medical scheme membership or health insurance cover.) These health vouchers would be redeemable solely for medical scheme membership and health insurance policies, including 'gap' cover and hospital cash-back plans. Costs would be met by minimising the fraud and inflated pricing which currently taint some 50% of the state's roughly R1 trillion rands' worth of procurement spending. In addition, some of the current public healthcare budget could be redirected into funding these health vouchers, as the cost pressures on the public healthcare sector would diminish with so many South Africans able to obtain treatment in the private sphere. Vouchers could also be partially funded by privatising urban public hospitals (as Sweden has done) and using some of the proceeds for this purpose;

[214] https://www.statssa.gov.za/publications/P0211/Presentation%20QLFS%20Q2%202023.pdf; CRA, *2023 Socio-Economic Survey of South Africa*, p554

1.9 Poor management of public hospitals and clinics should be countered by shifting from damaging cadre deployment and BEE policies to a new system of 'economic empowerment for the disadvantaged' ('EED'). This would give business 'EED' points for all their economic and social contributions: from jobs provided and taxes paid to topping up the health vouchers of the poor. This EED system would be far more effective in expanding opportunities for the great majority. These reforms would also restore efficiency and accountability in management, thereby strengthening internal discipline and ensuring compliance with key health norms and standards;

1.10 Public-private partnerships should also be encouraged, with the administration of public hospitals and clinics outsourced to private firms, under parameters set by the state, and via an open and competitive tendering process;

1.11 The private training of doctors, nurses, specialists, and other providers should be allowed and encouraged, so as to increase supply and help meet increased demand;

1.12 Regulatory restrictions on the establishment and expansion of private hospitals and clinics should be removed, while many more low-cost day hospitals should be introduced in both the public and the private sectors. Innovative mechanisms to increase competition and hold down treatment costs should be encouraged;

1.13 The government should embark on structural policy reforms aimed at promoting investment, raising the growth rate to 5% or 6% of GDP, and generating millions more jobs, as set out in the *IRR Growth Strategy* of 2023;[215]

1.14 As employment expands and earnings rise, South Africa should seek to introduce a Singapore-type of universal health coverage, in which all employees must save for their health needs and contribute to a privately administered basic health insurance plan – which helps to pay large hospital bills and costly out-patient treatments. South Africa should also adopt the four core ideas that underpin Singapore's health system: that people should take responsibility for their own health and avoid over-reliance on the state; that competition and market forces should be used to increase efficiency and reduce costs; that the government should intervene only where this is essential to help the poor; and that no healthcare service should be free at the point of delivery, as this encourages over-consumption.

The South African economy faces many major challenges, but it still has enormous strengths – especially when compared to many other emerging markets. It does not have to keep trailing far behind other emerging markets on annual growth rates and other key indicators. With the right policies in place in health and other spheres and the Eskom constraint removed, the country could start achieving annual growth rates of at least 5% of GDP. Growth of this magnitude would see its economy double every 14 years. This would be more

[215] https://irr.org.za/reports/occasional-reports/files/irr-growth-strategy-2023.pdf

effective than anything else in expanding employment, encouraging new enterprises, building prosperity, and steadily increasing the range of healthcare options that people can afford.

However, if such a 'new dawn' is to be achieved, the ANC's outdated and damaging NDR ideology, as described in *Countdown to Socialism*, must be jettisoned.[216] So long as the ruling party remains intent on pursuing a socialist (and ultimately communist) future, investment will be muted, growth will be limited or negative, and unemployment will persist at stubbornly high levels. This dismal situation is also precisely where South Africa now finds itself, with the economy projected to grow by only 0.4% of GDP in 2023 and with the unemployment rate at 32.6% in the second quarter of this year.[217]

Unconstitutionality of the NHI Bill

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'.[218]

The health department and many in the ANC alliance have claimed that the NHI is essential to fulfil this right. This is not so. The alternative solutions developed by the IRR would be far more effective in giving all South Africans access to a high-quality health system that is affordable to all and successful in meeting health needs.

By contrast, the proposed NHI system, as set out in the NHI Bill, will not increase access to healthcare on a progressive basis. Rather, it will deprive many South Africans of the access to healthcare that they currently enjoy. It will also drive many health professionals abroad, push out millions of taxpayers with scarce skills, and further cripple the economy. The NHI Bill is thus not a 'reasonable' legislative measure for the state to take. In addition, it will require a level of spending far in excess of the resources 'available' to the government. Against this background, adopting the NHI Bill will put the National Council of Provinces in breach of Section 27 – as well as its over-arching obligation to uphold the Constitution at all times.

The NHI Bill is also inconsistent with other guaranteed rights. Under the Bill, people wanting health services will have little option but to register with the NHI Fund – but this contradicts the right to freedom of association in Section 18 of the Bill of Rights.[219]

Private hospitals and clinics will retain their current ownership but will lose most of the usual powers and benefits of ownership – including the capacity to run their operations at a profit – under the comprehensive state controls to be imposed under the NHI Bill. The Bill will thus

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[216] Jeffery, A. (2023): *Countdown to Socialism*. Jonathan Ball, Cape Town.
[217] South African Reserve Bank (2023), Statement of the Monetary Policy Committee (July 2023), p. 2-3, https://www.resbank.co.za/content/dam/sarb/publications/statements/monetary-policy-statements/2023/july-/Statement%20of%20the%20Monetary%20Policy%20Committee%20July%202023.pdf; https://www.engineeringnews.co.za/article/unemployment-rate-decreases-to-326-2023-08-15
[218] Section 27(1)(a), (2), Constitution of the Republic of South Africa, 1996
[219] *Business Day* 20 August 2019

give rise to uncompensated regulatory expropriations that are in breach of Section 25 (the property clause) and hence in conflict with the Constitution.

Moreover, confining medical schemes to complementary services – which will prevent them from remaining in business and in practice compel them to transfer their reserves to the NHI Fund – is also inconsistent with the right to property in Section 25 of the Constitution.

In addition, barring healthcare professionals from running their private practices as they see fit – as the state controls set out in the NHI Bill will do – is inconsistent with the right of every citizen 'freely…to choose their own profession' under Section 22 of the Bill of Rights.

Under Schedule 4 of the Constitution, moreover, health services are listed as an area of 'concurrent' national and provincial legislative competence. Provincial health administrations thus play a major part in the provision of public health services and cannot be excluded from exercising their concurrent powers over health services without first amending Schedule 4. The NHI Bill ignores this in proposing that many of the healthcare functions now resting with provincial administrations should be transferred either to national or district levels.

In addition, Section 217 of the Constitution requires that the procurement of goods and services by state entities must be done 'in accordance with a system which is fair, equitable, transparent, *competitive,* and cost-effective'.[220] Yet the NHI Bill provides, in Clause 3(5), that 'the [NHI] Fund is exempt from the Competition Act of 1998…to enable it to fulfil its mandate as a single purchaser and single payer'.[221] This attempt to exempt the NHI Fund from the provisions of Section 217 is clearly in breach of what the Constitution requires.

Fortunately, however, it is not necessary for the government to infringe the Constitution in order to achieve universal health coverage and high standards of healthcare for all. The practical reforms needed to achieve these goals have also already been set out – and all that is needed is the political will to jettison the NHI Bill and adopt these far better alternatives.

South African Institute of Race Relations NPC (IRR) **15th September 2023**

[220] Section 217(1), 1996 Constitution, emphasis supplied by the IRR
[221] Clause 3(5), Bill