NATIONAL HEALTH INSURANCE POLICY BILL REVIEW

Expert review of the National Health Insurance bill submitted by the Minister of Health to Parliament in 2019 for submission to Parliament as a response to the request for public comment

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PART 1: INTRODUCTION

This part provides background on the author, purpose and structure of the report.

EXPERTISE

1. I presently hold the Chair of Social Security Systems Administration and Management studies at the Wits School of Governance.

2. I am an economist that has been working in the fields of health and social security from 1989 to the present. This has involved inter alia the following employment and activities:

    2.1. An economist in the Central Economic Advisory Services of the Department of Finance (now National Treasury);

    2.2. An economist within the Industrial Development Corporation;

    2.3. A researcher with the Centre for Health Policy (University of the Witwatersrand);

    2.4. A consultant to the Melamet Commission of Inquiry into Medical Schemes;

    2.5. The director of finance for Gauteng Department of Health;

    2.6. The advisor to the CEO of the Council for Medical Schemes;

    2.7. A member of the Taylor Committee of Inquiry into a Comprehensive System of Social Security;

    2.8. Member of the Ministerial Task Team into Social Health Insurance;

    2.9. Consultant to the Inter-departmental Task Group on Social Security chaired by National Treasury;

    2.10. Chair of Social Security Systems Administration and Management studies at the Wits School of Governance;

    2.11. Developer of the modelling framework for the National Department of Health's (NDOH) human resource strategy of 2011;

    2.12. Developer of the modelling framework for the restructuring of the National Tertiary Services Grant and the Health Professions Training and Development Grant for the NDOH;

    2.13. Developer of the Social Budget database and publications in partnership with the Department of Social Development; and

    2.14. Lead economist in the Health Market Inquiry for the Competition Commission of South Africa (until December 2017).

PURPOSE OF THIS REPORT

3. This report is a submission to Parliament as a comment on the National Health Insurance Bill (NHIB).

4. This report takes the form of an expert evaluation of the NHIB.

5. This evaluation will cover the following areas:

    5.1. An evaluation of the justification of the version of NHI proposed in the NHIB;

    5.2. The rationality of the institutional and financial proposals;

    5.3. The rationality of the envisaged governance approach;

    5.4. The lawfulness of the implied multi-level government arrangements;

    5.5. The lawfulness and rationality of the proposed change in coverage entitlements; and

    5.6. The reasonable policy alternatives that would not risk a failure of coverage.

STRUCTURE OF THIS REPORT

6. This report is broadly divided into context-setting sections, contained in **Part 2**, which outline the present organisational framework of universal health coverage (UHC) in South Africa, together with an assessment of the weaknesses. This is followed in **Part 3** by a review of the national health insurance (NHI) proposals as presently embodied in the NHIB currently before Parliament in South Africa. **Part 4** provides a brief summary of key findings arising from this report.

PART 2: OVERVIEW OF THE STRUCTURE AND CONDITION OF THE SOUTH AFRICA HEALTH SYSTEM

This part provides a contextual review of the present structure and performance of the South African health system. This serves as supporting material for the review of the National Health Insurance proposals provided in **Part 3**.

BACKGROUND ON THE SOUTH AFRICAN HEALTH SYSTEM

7. The South African health system can be divided into four parts which are governed through three spheres of Government. This is in accordance with the Constitution of South Africa (Constitution) which makes specific reference to the right to healthcare (in section 27) and functional responsibilities of the various parts of the state (Republic of South Africa, 1996a).

8. Three of the parts relate to the public provision of health services and include: the national sphere which oversees national policy and implementation; the provincial sphere which has the constitutional mandate for health services, which is held concurrently with the national sphere;[1] and local government, which has the mandate for non-clinical health functions – such as environmental health and sanitation.

9. From 2003 local governments are only permitted to provide health services where they have been so assigned by a provincial Member of the Executive Council (MEC).[2] Although the public sector technically also offers social health insurance in the form of compensation for occupational injuries and diseases this amounts to less than 1% of GDP and provides coverage for private sector services for employees only.

10. The fourth part of the health system is made available through private health service providers and is funded by private health insurance (referred to as medical schemes). The private health system is predominantly regulated through national legislation[3] under the jurisdiction of a national Minister of Health. Private hospital licensing however occurs at a provincial level, although it is possible for national government to legislate if they so wish.

11. The public health system is universally free at point-of-service for the entire population except for access to the hospital system which is subject to a means test. Lower income groups can access the public hospital system without attracting fees while higher income groups are required to pay the full cost of care.

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[1] This can be found in **schedule 4**, **Part A** of the **Constitution** which lists the functions that are to be held concurrently by both national and provincial governments (Republic of South Africa, 1996a).

[2] This is in terms of **section 32** of the National Health Act (National Department of Health, 2003).

[3] This includes the regulation of all health professionals, medicines, medical products, medical devices, pharmacies, and medical schemes.

12. Prior to 1994 the primary care system attracted minor co-payments which were removed in 1995. Access to the public hospital system has however always been means tested and has persisted to the present time.

13. Altogether the combined public and private systems technically comply with the objectives of universal health care (UHC) in that virtually the entire population has access to pre-paid healthcare, i.e. where service access is predominantly free at point-of-service (van den Heever, 2016) (International Labour Office, 2017).

14. Historically the need for income-earners to pay for public hospital services influenced the emergence of medical schemes, which in the period to the mid-1980s largely took the form of not-for-profit employer-based health insurers.

15. Medical schemes initially indemnified private professional services (general practitioners and specialists) and public hospital care. However, following severe fiscal constraints facing the country from 1985, budgets for public hospitals became more restrictive, resulting in the expansion of fully private for-profit private hospitals established by medical practitioners moving out of the public sector.[4]

16. Whereas in 1986 the public sector had an estimated 117,842 beds and the private sector an estimated 6,125, by 2010 the private sector increased to 31,067 compared to 88,920 in the public sector (**Table 1**). (National Department of Health, 2002; van den Heever, 2012)

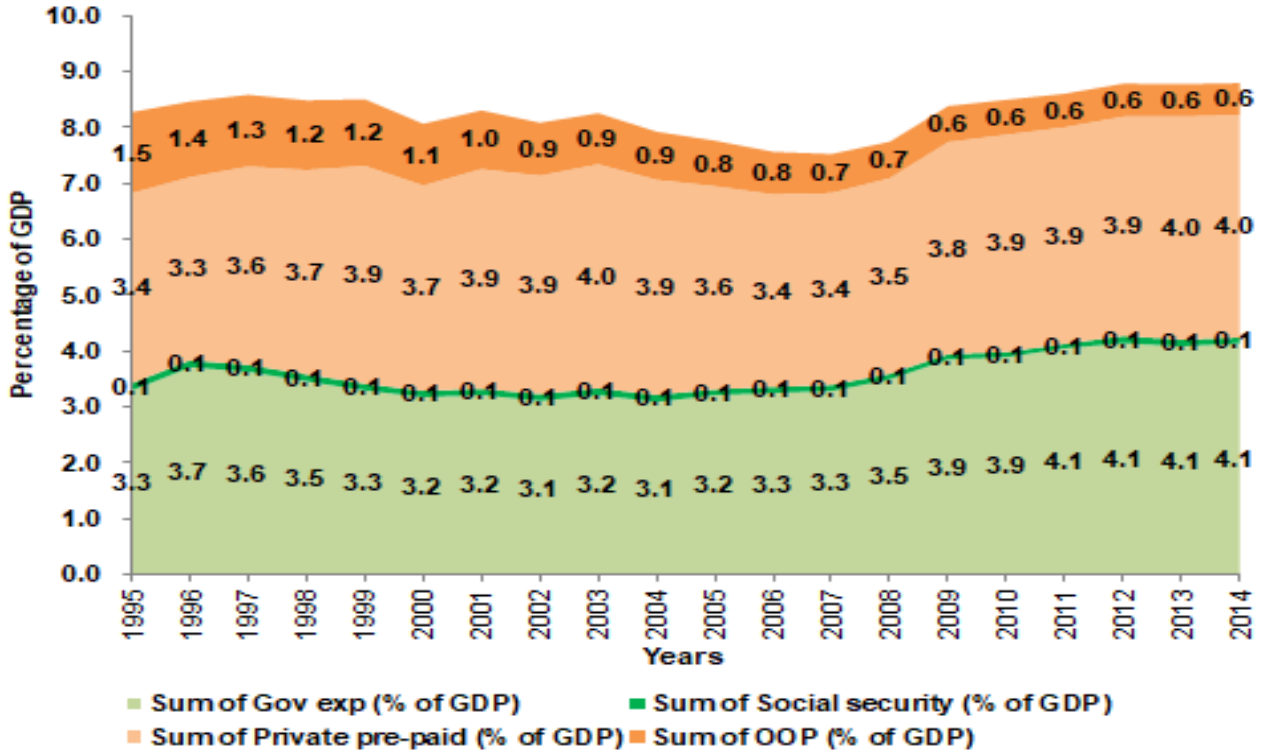
Table 1: Private and public hospitals and bed estimates from 1976 to 2010

Year	Private		Public	
	Hospitals	Beds	Hospitals	Beds
1976	25	2,346		
1986	65	6 125 (est)		117 842 (est)
1989	101	10,936		
1998	162	20,908	343	107,634
2010	216	31,067	410	88,920

Source: (van den Heever, 2012)

[4] While the public hospital system charged private patients it under-recovered relative to actual costs incurred.

Figure 1: Health expenditure in South Africa expressed as a percentage of Gross Domestic Product 1995 to 2014

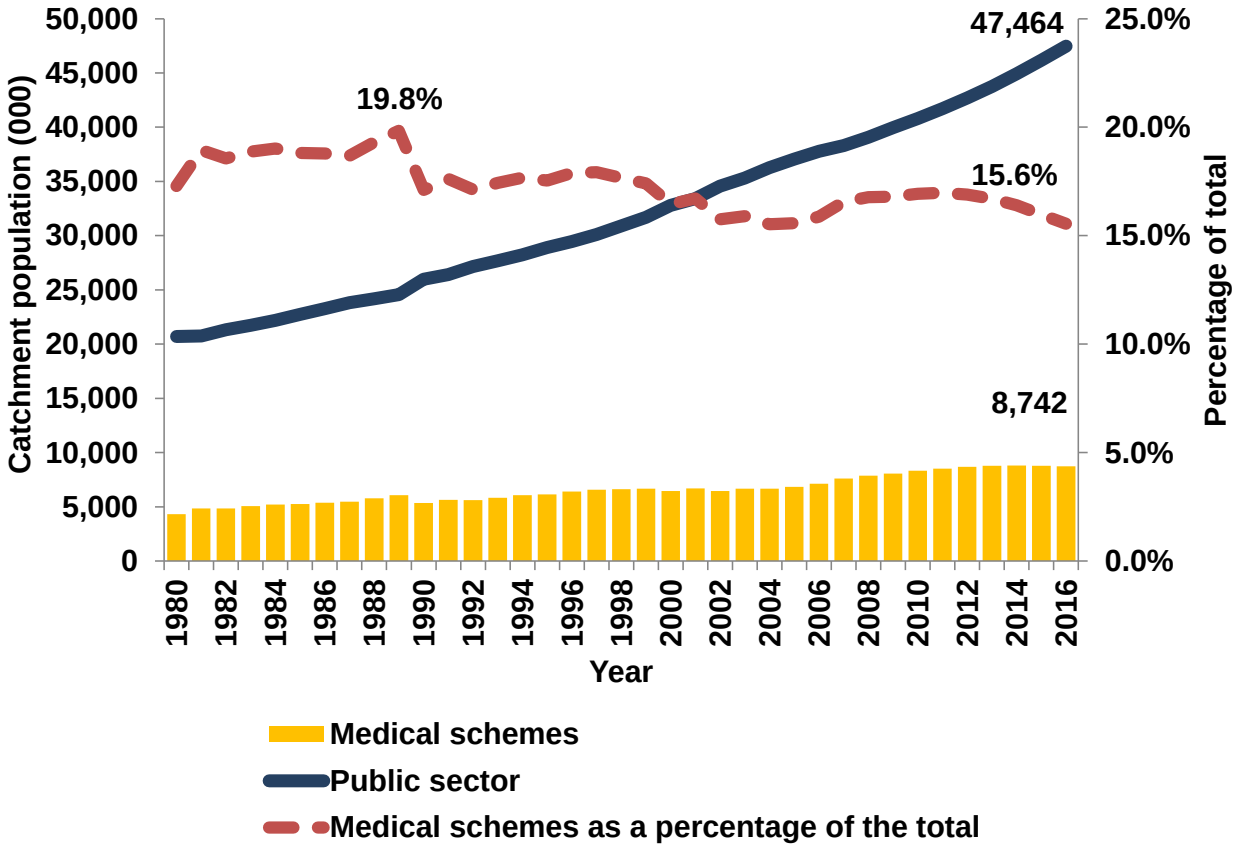


Source: (World Health Organisation, 1995 to 2014)

17. The public and private health systems have therefore developed in tandem, with the public sector serving those without adequate incomes and the private, via medical schemes, serving those with adequate incomes (i.e. mainly those households where the breadwinners earn in excess of the threshold required to pay individual taxes) (van den Heever, 2016). Both the public and private systems spend roughly the same percentage of GDP. The public systems accounts for 4.1% of GDP, medical schemes roughly 4% (private pre-paid in **figure 2**) with an additional 0.6% of GDP spent out-of-pocket[5].

[5] It is likely that this is an under-estimate. Ironically, out-of-pocket expenditure in South Africa is mainly incurred by medical scheme members when they are balance-billed by medical professionals. Out-of-pocket expenditure in South Africa could be argued to be non-catastrophic in nature as all highly specialised care is either covered through the public system or medical schemes (van den Heever, 2016).

Figure 2: Catchment populations served by the public sector[6] and the system of medical scheme (1980 to 2016)



Sources: Medical schemes beneficiaries (Council for Medical Schemes, 1980 to 2016); national population (Statistics South Africa, 1980 to 2017)

18. While covered[7] expenditure is evenly divided between the public and private systems the populations served are quite different. In 2016 the medical schemes population served 15.6% of the total population (down from 19.5% in 1989) or 8.7 million. This compares to 47.5 million effectively served by the public sector (**Figure 2**). While a fair number of non-medical scheme beneficiaries make use of private doctors on an out-of-pocket basis, very few are able to make use of private hospital services without cover. This split is therefore an accurate indicator of

[6] The public sector population is calculated by subtracting the reported medical schemes beneficiaries (i.e. the total membership of medical schemes) from the total population for South Africa.

[7] Excluding out of-pocket payments.

public and private hospital catchment populations as virtually no medical scheme beneficiaries make use of public hospital services.

19. An estimated 5 million people however fall outside the means test for access to free public hospital services and cannot afford medical scheme cover (van den Heever, 2016). This can be regarded as unfair and one of the (correctable)[8] weaknesses in South Africa's UHC framework.

20. In practice, however, technical difficulties with the efficient application of the means test at point-of-service makes it unlikely that many end up being required to pay. Most public hospital revenue collected is actually from medical scheme members, the financial value of which in 2016 made up only 0.5% of total medical schemes hospital expenditure and 0.2% of total claims expenditure (Council for Medical Schemes, 1980 to 2016).

[8] Policy recommendations in 2002 (National Department of Health, 2002) and 2005 (Ministerial Task Team on Social Health Insurance, 2005) were made to remove the means test while retaining the requirement for medical schemes' patients to pay the full cost of services to date there has been no movement toward implementation due to perceived conflicts with a particular version of "National Health Insurance" under consideration by Government from 2007 (van den Heever, 2016).

ORGANISATION OF THE HEALTH SYSTEM – A CRITICAL REVIEW

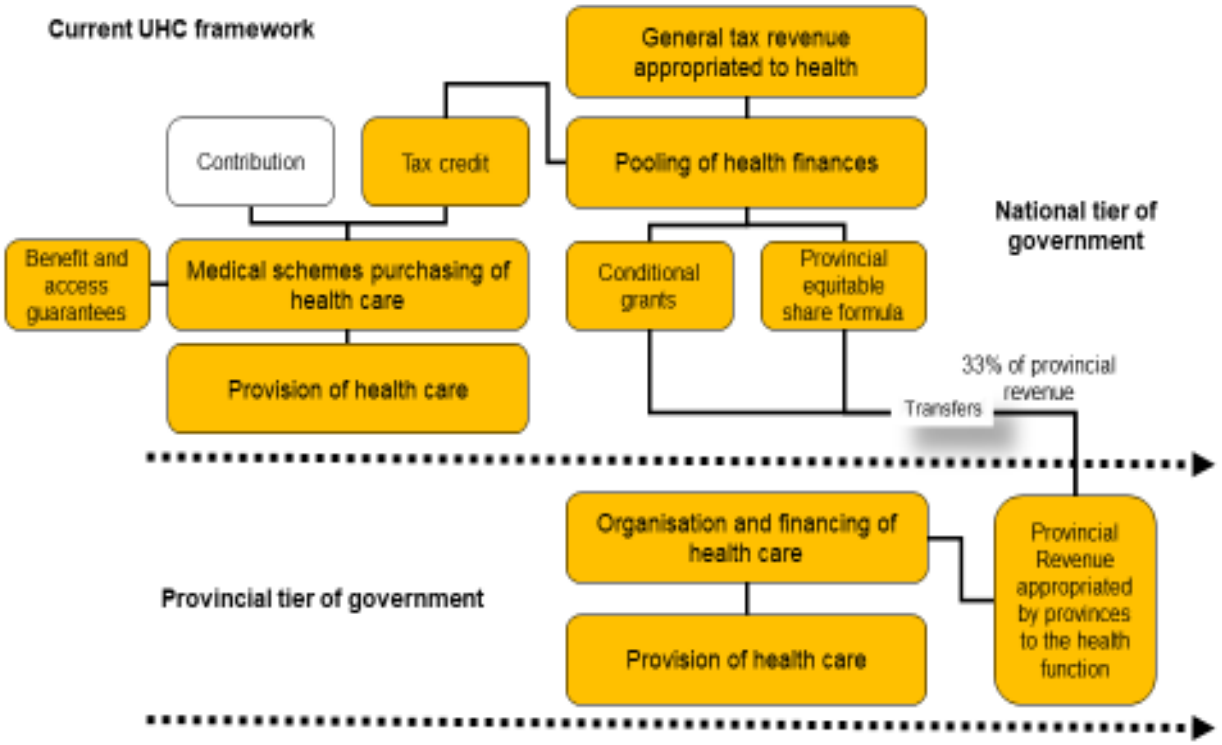
Existing framework

21. South Africa's existing UHC framework involves a division of the health system into a subsidised public health service, delivered through the provinces and a regulated system of medical schemes where the bulk of coverage is funded through a system of pre-paid health insurance contributions **(figure 3**).

22. Roughly 33% of provincial revenue is allocated using a combination of conditional and unconditional grant allocations in lieu of provincial taxes (discussed further below) referred to as the provincial equitable share (PES) allocation.

23. Medical scheme contributions are partially subsidised by government using a tax credit, which works out at roughly *17% less* than the per-capita subsidy (see **table 10**) provided to users of the public sector. The remainder of the contribution is paid for by the medical scheme member from household disposable incomes.

Figure 3: Existing UHC framework



24. Medical schemes are regulated in terms of the Medical Schemes Act (National Department of Health, 1998) and in accordance with a policy framework outlined in terms of the NHI

Committee of 1995 (Department of Health, 1995), the White Paper of 1997 (National Department of Health, 1997a) and a consultation document produced by the National Department of Health (National Department of Health, 1997b).

25. Provincial health departments form part of a multi-level government arrangement that is fairly conventional by international standards and is provided for in the Constitution (finalised in 1996) (Republic of South Africa, 1996b). In terms of this framework, public functions which require accountability to local users are delivered through devolved parts of government. It is for this reason that public health services and basic education are delivered through provincial governments. This framework is consistent with international approaches and trends which seek to decentralise health services to achieve both equity and efficiency objectives.

> "*In the past three decades, health reform has become commonplace in most countries. As part of such reforms decentralised governance of health systems has been adopted in some countries as a subset of broader health reforms or as a preferred management strategy … . The rationale for this policy choice varies across countries. A primary objective underpinning this choice is to improve overall health system performance … . The expectation is that decentralisation provides the opportunity for health systems to attain both technical and allocative efficiencies, empower local governments, increase accountability, and make gains in many areas including quality, cost and equity. Furthermore, some of the compelling arguments for decentralised governance of health systems is the imperative to make health services responsive to local population needs and to improve access and quality of health care … .*" (Sumah, Baatiema, & Abimbola, 2016, p. 1184)

> "*Decentralisation has been defined in several ways by several scholars … . Essentially, it is conceptualised as the transfer of authority and power in the public planning, management and decision making from national or higher level of government to sub-national or lower levels … .* " (Sumah et al., 2016, p. 1184)

26. In a review of the equity implication of decentralisation the following findings were made from a multi-country review of evidence:

> "*With respect to inequities in health care use, decentralisation curtailed disparities in Spain and reduced inequalities in Canada. The role of pre-existing socio-economic factors is evident. In situations where financial barriers to access are prevalent,*

disparities in healthcare usage are commonplace, as experienced in China and Switzerland." (Sumah et al., 2016, p. 1191)

"*The literature presents a positive relation between decentralised governance and health status or outcome*." (Sumah et al., 2016, p. 1191)

"*Where substantial central government transfers exist, coupled with cross subsidisation systems, spatial inequities in financing health care were minimal as exemplified in Canada, Chile, Columbia and Spain. The reverse was the case in China and Switzerland*." (Sumah et al., 2016, p. 1191)

27. For health systems to be responsive, equitable and efficient, the evidence suggests that the authorities that plan, finance and deliver the care should be directly *accountable to user populations through the design of governance frameworks*. Equity objectives are achieved through supportive systems of national and, where necessary, sub-national transfers that ensure an equitable distribution of health resources.

28. The public finance framework for the public health system in South Africa is consistent with international approaches, with many health systems successfully implemented through devolved government structures (provincial and local governments).

29. The system of national transfers is consistent with the logic of centralised pooling required to achieve equity, while the decentralised planning a delivery are necessary for improved efficiencies and local responsiveness. *It is decentralisation with accountability that improves responsiveness and efficiencies, <u>not centralised purchasing</u>*.

30. Strategic purchasing decisions, by way of contrast to the NHI framework, involve local decisions made by decentralised health authorities in accordance with their own priorities. Depending upon the country context, a mix of public and private providers are used.

31. While many of the features of a well-performing public health system are in place, the failure to offer efficient and equitable health services, as discussed later, is largely due to the system of political appointments that have been institutionalised since 1994 (this is also discussed later).

32. Were this to be changed, the performance of the health system would be structurally improved. This weakness in government has been noted in the National Development Plan (NDP) with associated recommendations.

"*The public service needs to be immersed in the development agenda but insulated from undue political interference*." (National Planning Commission, 2011, p. 407)

"***Stabilise the political-administrative interface**. Build a professional public service that serves government, but is sufficiently autonomous to be insulated from political patronage. This requires a clearer separation between the roles of the political principal and the administrative head*." (National Planning Commission, 2011, p. 410)

33. It is however noteworthy that the insights reflected in the NDP and the associated recommendations are yet to be deliberated on and implemented nearly nine years on. As a consequence the structural inefficiencies resulting from patronage continue unabated, at least in nine of the provinces.

The (largely) free public health system

34. Although the public health system is delivered at a provincial level, the funds are raised predominantly from national taxes and allocated to provinces as revenue through a mix of unconditional and conditional transfers.

35. The Constitution allocates the function "health services" to provinces concurrently with national government in schedule 4(A). The function "*ambulance services*" is however the *exclusive domain* of provinces as indicated in schedule 4(B).

36. Section 146 of the Constitution clarifies the role of national government in relation to functions it holds concurrently with provinces of which subsections (1) and (2) are most relevant to healthcare.

"*146. (1) This section applies to a conflict between national legislation and provincial legislation falling within a functional area listed in Schedule 4.*

(2) National legislation that applies uniformly with regard to the country as a whole prevails over provincial legislation if any of the following conditions is met:

(a) The national legislation deals with a matter that cannot be regulated effectively by legislation enacted by the respective provinces individually.

(b) The national legislation deals with a matter that, to be dealt with effectively, requires uniformity across the nation, and the national legislation provides that uniformity by establishing—

(i) norms and standards;

(ii) frameworks; or

(iii) national policies."

37. In terms of this framework, there are constraints on the extent to which national government intervenes in the financing, planning and delivery of health services*. It is plainly the intention of the Constitution that healthcare is organised and delivered locally, with strategic elements that are outside of the natural domain of provinces addressed at a national level*. These interventions are confined to norms and standards, frameworks or national policies (by which is self-evidently policies that are national rather than provincial in character).

38. To achieve fiscal harmonisation consistent with South Africa's multi-level constitutional design[9] a substantial portion of nationally raised taxes (43.3% in 2018) are allocated to provinces. Local governments, which have their own tax bases, receive 9% (in 2018) of the nationally allocated budget. The rest of their revenue is made up of their own revenue from rates, taxes and user fees.

39. Up to 82.4% (2018) of the provincial distribution of national revenue is unallocated (i.e. not subject to conditions, leaving provinces free to allocate as they wish) and distributed using the PES formula which is based on *weighted population-based criteria*. A significant part of the remainder comes from conditional grants, the bulk of which are for health-related functions. (National Treasury, 2018a)

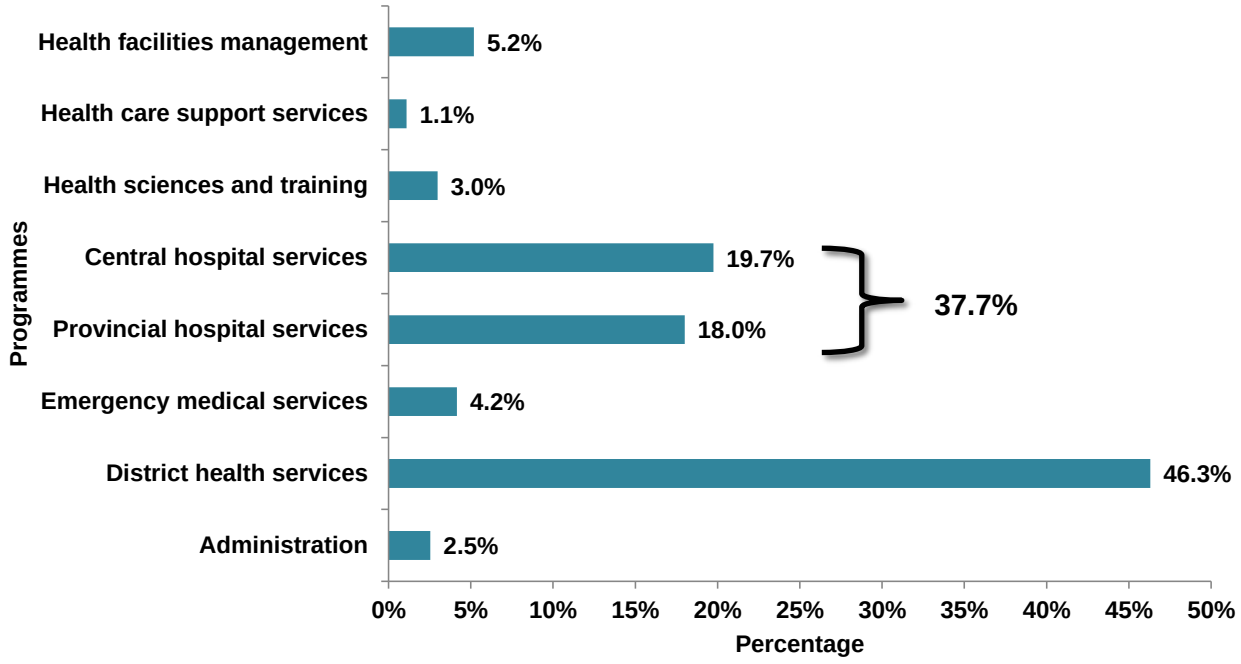
40. The two main functional responsibilities of provincial governments are health services and basic education, with health allocated 32.3% of the overall budget for provinces. Of this 37.7% is for provincial (specialist) and tertiary/central (super-specialist and academic) hospitals. This excludes the allocation for district, non-specialist, hospitals which fall within the largest programme, district health services, which constitutes 46.3% of the overall provincial allocation, together with clinic-based care and the HIV and AIDS treatment). (**Figure 4**)

41. Provincial governments have sought to prioritise primary care services (district health services) relative to hospital services since 2000, with the trend evident in the allocations from 2012/13 reflected in **figure 4**.

[9] By this is meant consistency with the intention that provincial and local governments have significant autonomy. However, this autonomy is threatened if all revenue to fund provinces is raised nationally. For this reason most of the national revenue is allocated on an unconditional basis.

42. The public health system, while mainly funded from national taxes, involves no formal nationally organised system of resource allocation dedicated to funding a public health package of services. While the PES is allocated to provinces using a population-weighted formula, this acts only as unallocated revenue. While there are substantial health-related conditional grants, these either top-up the PES or finance vertical programmes such as those for HIV and AIDS and TB. Provincial governments are therefore broadly free to allocate funds to health as they see fit.

Figure 4: Breakdown of provincial health expenditure by programme in 2017/18



Source: Based on (National Treasury, 2018a)

43. The purpose of the PES is to ensure that provinces have sufficient revenue to perform their functions as outlined in the Constitution.

    43.1. They are <u>purposefully unallocated</u> as they are a substitute for provincially raised taxes, for which provinces have powers.

    43.2. However, given the very different tax bases of the nine provinces, provincially raised general taxes would have required the implementation of *some form of tax-capacity equalisation mechanism* to ensure a fair distribution of revenue across all the provinces.

43.3. Raising the taxes nationally instead and distributing them through a formula is regarded as considerably more efficient, and furthermore avoids many perverse incentives which would arise at the provincial level given the variation in tax bases (see for instance Ajam, 2015).

43.4. While the financing of the PES is raised at a national level, their purpose is expressly not to finance national functions. The PES is merely an efficient means to raise and distribute provincial tax revenue.

44. When the provincial populations are adjusted to remove beneficiaries covered by medical schemes, a fair degree of consistency in the overall allocation by province is achieved, although there are some outliers (notably Limpopo and Mpumalanga) (**figure 5**).

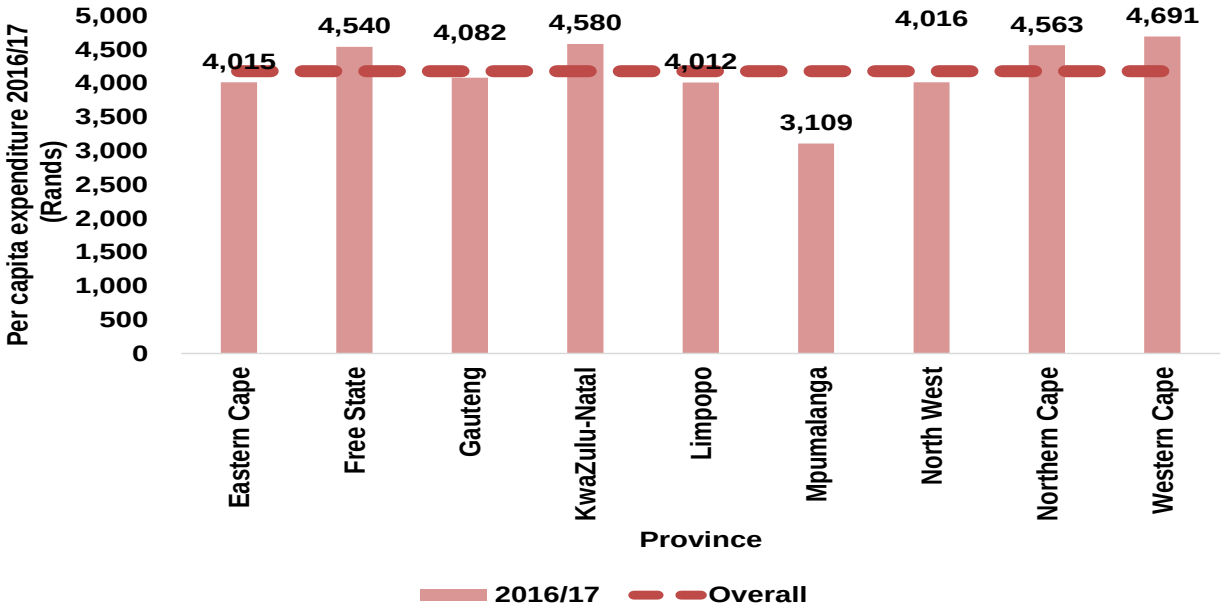
45. The largest province in South Africa, which contains the largest share of specialised hospital services, is however below the average for the country as a whole. This is despite receiving conditional grant funding for tertiary services and for medical teaching and training.

46. Gauteng also has the fastest growing population, having increased in size by roughly 25% in 10 years. This suggests that the Gauteng legislature has been de-prioritising health services relative to the Western Cape, a province with broadly similar socioeconomic, demographic and economic trends.

47. While the public health budget does address national considerations through conditional grant funding, the overall package of services is not determined in accordance with national criteria. The final national allocations for health, as occurs in many similar situations around the world, are merely aggregations of locally determined budgets.

48. While fiscal harmonisation achieves a strong degree of fiscal fairness between the provinces, it cannot ensure that public health services are equitably distributed. This is largely a consequence of the failure of the NDOH to develop a coherent framework of national conditional grants. Largely they remain poorly calibrated, with significant gaps in the range and specificity of the conditional grants framework. As already noted above, in the absence of coherent national pooling, inequity in the distribution of services is inevitable.

Figure 5: Public sector per capita budget allocation with the medical schemes population removed for all provincial governments in South Africa for the 2016/17 financial year (2017/18 prices) (Rands)



Source: The budget data is based on (National Treasury, Accessed 2018); the population data is based on (Statistics South Africa, 1980 to 2017) adjusted for the medical schemes population using (Statistics South Africa, 1999 to 2017)

Supervision of quality of care

49. Public hospitals have to date not been regulated by independent agencies or structures. They are instead directly administered by provincial administrations.

50. Private hospitals however are "regulated" by the same provincial administrations who license the private beds on application. However, no uniform criteria guided by a strategic policy framework are used. The provincial governments have consequently approved substantial bed increases over time without giving consideration to factors such as ownership, for-profit status and risks to provincial health services (Competition Commission, 2019; Council for Medical Schemes, 2008).[10]

[10] In particular poaching of staff and the risk of moonlighting – which appears endemic in all provinces except the Western Cape (For evidence of nurse moonlighting see L. C. Rispel, Blaauw, Chirwa, & de Wet, 2014; It is expected that moonlighting by medical practitioners is as significant if not worse).

51. A recent addition to the governance framework for public hospitals has been the Office of Health Standards Compliance (OHSC) which has as its purpose the implementation of a system of quality assurance standards applicable to both the public and (ultimately) private sectors.

52. These include: *"[m]onitoring and enforcing compliance by health establishments with norms and standards prescribed by the Minister of Health in relation to the national health system*"; and "[*e]nsuring consideration, investigation and disposal of complaints relating to non-compliance with prescribed norms and standards for health establishments in a procedurally fair, economical and expeditious manner*." "*The term health establishment refers to both public and private healthcare services and facilities (see formal definition below). It includes hospitals and primary healthcare clinics and extends to emergency medical services, hospices, private medical practices and institutions offering frail care*." (Office of Health Standards Compliance, 2018)

53. Although the OHSC identifies itself as independent and impartial[11] the entire leadership is appointed by the national Minister of Health and reports to this office. The discretion for political interference (or private interest interference operating through the executive of government) in the independent operations of the OHSC is therefore high, particularly as there are political implications to the reviews and investigations.

54. Despite implementing a system of quality assurance standards in 2012, and inspecting numerous facilities, the OHSC has only published one partial review of the public hospital system – with most hospitals failing to meet quite basic requirements (Office of Health Standards Compliance, 2016/17). However, the consistency of the analysis has been questioned by the media.

55. At least one media assessment of the OHSC, after extracting certain of the inspection results by taking legal action (prior to the release of the official report), found that the reporting by province bore no relation to publicly available outcome measures (Khan, 2016).

56. Overall there is no evidence that the OHSC has had any influence on the performance of public hospitals, and has not as yet been extended to private facilities. While there is potential for an

[11] According to the mission statement the OHSC "*We act independently, impartially, fairly and fearlessly on behalf of the people of South Africa in guiding, monitoring and enforcing health care safety and quality standards in health establishments*." [http://ohsc.org.za/who-we-are/, downloaded 28 May 2018].

improvement in hospital governance through the implementation of a completely independent regulator of quality, the OHSC model will in all likelihood not achieve this: as it is not independent; is not required by legislation to operate in a transparent manner; and fails to address quality improvement techniques or to measure clinical outcomes.

57. An important critique of public hospital performance in South Africa arises from the facility-based maternal mortality ratios (MMRs)[12] by province. If these are used as a proxy indicator of hospital management performance it can be assumed that, in the absence of better information, other facility-based services perform equally poorly.

58. There are presently no supervisory structures in either the public or private health systems that review or even publish waiting times, quality based on outcomes, or any other factors that would meaningfully report on the value to users of services. However, public perceptions of private health services are generally very high in comparison to public services (Ranchod et al., 2017; Statistics South Africa, 1999 to 2017). Significant waiting periods for elective surgery of any form in the private sector are generally unheard of.

59. However, the HMI notes that It *"… is generally believed that the private health sector provides better quality care when compared to the public sector. However, it is difficult to assess objectively as the SA private market does not have any standard means of comparing the quality of health services or outcomes. There is no measure of cost-effectiveness in the private healthcare sector*." (Health Market Inquiry (South Africa), 2018, p. 6)

60. Where a common standard of comparison is applied to available data (which excludes outcomes) private sector scores are on average higher than those for the public sector with less variation between individual hospitals in the private sector. Significant differences[13] in performance are identifiable for the following elements: "resuscitation systems; medical equipment management; quality management and improvement; risk management; prevention and control of infection; and maintenance service." (Ranchod et al., 2017, p. 106)

[12] Which is the number of women who die as a result of childbearing, during the pregnancy or within 42 days of delivery or termination of pregnancy in one year, per 100 000 live births during that year.

[13] A 50 point difference on average for the six elements.

Access to health insurance (medical schemes)

61. South Africa's system of medical schemes provides the predominant form of lifetime coverage for families regarded as having adequate incomes. Adequacy here can be regarded as families with income earners who are active taxpayers. Income earners earning below the threshold required to pay income tax are generally unable to afford medical scheme coverage.

62. The private health system is mainly funded through private contributions made to non-profit medical schemes of which there are 81 as at December 2016 (down from 129 in 2005). Although the medical schemes system is technically voluntary, it has many of the features of a mandatory system through protected access for families and a contribution subsidy offered by way of a tax credit.

63. There were 21 open commercially-oriented schemes in 2016 (down from 46 in 2005) that take on individual members as well as groups (employers joining as groups); and around 60 restricted membership schemes which are restricted to an employer or industry (down from 83 in 2005) (Council for Medical Schemes, 1980 to 2016).

64. While there is no mandatory requirement to take up medical scheme coverage in South Africa, access is guaranteed through: open enrolment applicable to open schemes (i.e. medical schemes cannot decline an application); mandatory minimum benefits that schemes must offer (specified in legislation in the form of condition-treatment pairs); and contributions that cannot vary according to the health status of an individual or group. Continuity of membership is also protected, as schemes cannot exclude anyone from coverage, including at retirement. This framework was introduced in the Medical Schemes Act No.131 of 1998.

65. Historically medical scheme principal members (the contributor on behalf of the family) have also been able to benefit from a tax subsidy. While originally in the form of a tax deduction largely in the hands of the employer, the subsidy is now structured as a tax credit with a fixed financial value roughly equivalent to the per capita expenditure on the public health system (Department of Social Development, Wits School of Governance, & Oxford Policy Management, 2017). This is effectively an off-balance-sheet transfer from government (implicitly) funded by general taxes. (See **table 2** for the comparison between the implicit in-kind subsidy provided through free services and the explicit tax subsidy provided to medical scheme beneficiaries.

Table 2: Tax expenditures for healthcare per beneficiary[14] compared to public health per capita expenditure for the Years 2008/9 to 2013/14 (South African Rands) (2013 prices)

Health system	2008/9	2009/10	2010/11	2011/12	2012/13	2013/14
Medical schemes	2 117	2 239	2 342	2 385	2 694	2 517
Public sector	2 426	2 719	2 832	2 981	3 057	3 052

Source: (Department of Social Development et al., 2017, p. 39)

66. A feature of this framework is that no distinction is made between individual and group coverage as occurs, for instance, in the United States or in voluntary supplementary health insurance markets. If an employer chooses an open scheme, all employees and their family members are able to participate in the same scheme.

67. If an employee chooses to leave that employer they are able to continue on the same open scheme without any change in contributions. Furthermore, any individual can join any plan (referred to as an option) of an open scheme and participate together with members who have joined as part of groups with the same premium or contribution.

68. To address the risk of anti-selection[15] a general three month and twelve month pre-existing condition waiting period can be applied for any break in medical scheme membership longer than 90 days. This occurs only on joining the system, and cannot be applied every time a member moves from one scheme to another if this movement is timed to occur by 1 January of any given year.

69. Once all waiting periods have been exhausted, no further waiting periods are permitted for movements between schemes[16] or between options (the specific plan joined on a medical scheme). Long-term anti-selection is addressed through a late-joiner penalty regime[17] which

[14] While the tax subsidy is effectively paid to the principal member, it implicitly accrues to the entire family that is covered through the principal member's contribution.

[15] Anti-selection refers to the risk faced by voluntary insurance schemes where applicants no more about their risk of making a claim from the insurer than the insurer and use this information to take up insurance only when the probability of making a claim is either certain or very probable.

[16] While schemes can apply limited waiting periods for member movements within a financial year, equivalent to a calendar year, these can only apply to non-mandatory benefits.

[17] This is an unfunded version of a lifetime community rate, with a funded version implemented in the supplementary health insurance system of Australia.

permits schemes to load an individual's premium on a sliding scale for every five years that they have not been on a medical scheme over the age of 30.

70. For higher income groups there is no alternative regime that offers financial risk protection for access to services where catastrophic health expenses are covered, as *they do not have free access to state hospital-based services*. The tariff schedule applicable to public hospitals is only at a slight discount to private sector tariffs and will therefore prove financially ruinous if funded on an out-of-pocket basis. Medical schemes coverage is therefore substitutive of state care and cannot be regarded as top-up or supplementary insurance as occurs *inter-alia* in Australia or the United Kingdom.

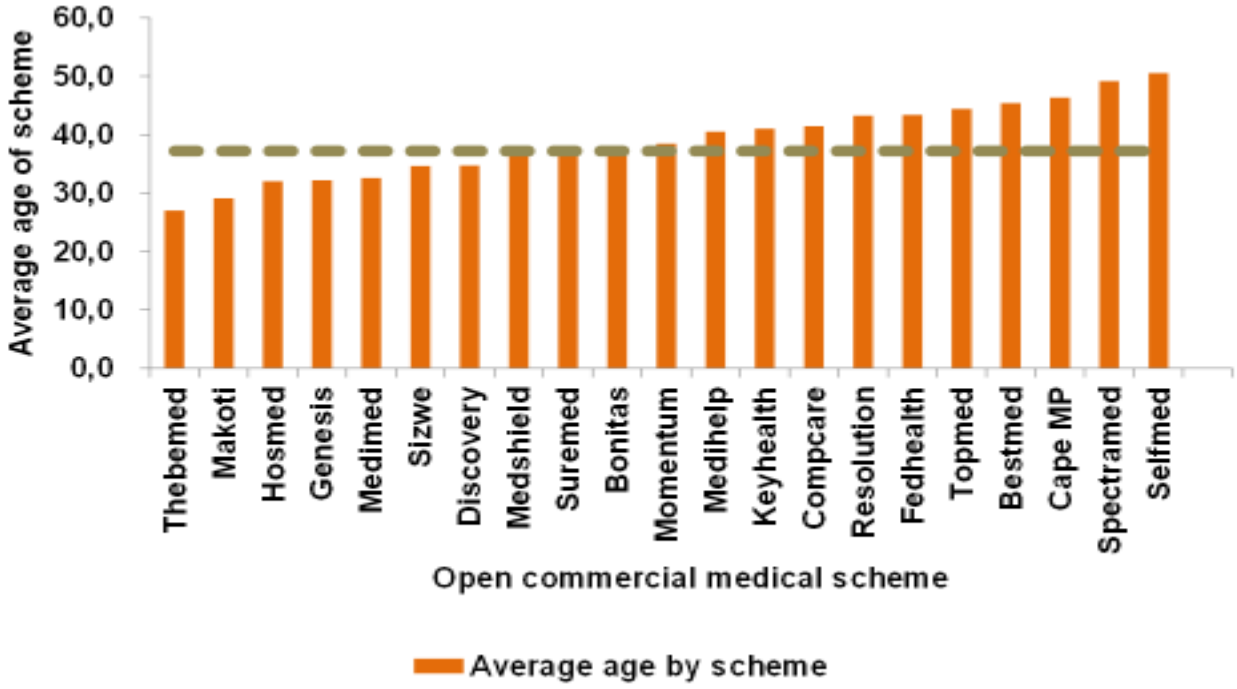
71. The interaction between the regulatory requirements for open enrolment, community rating and mandatory minimum benefits, while not necessarily generating a full-blown anti-selection problem, does expose competing (open) medical schemes to the demographic profile they end up with. As they can't select or penalise poor risks they must manage whatever demographic and risk profile emerges.

72. **Figure 6** shows that there is a substantial age variation amongst competing open medical schemes. It is for this reason that a risk equalisation mechanism was recommended by various processes and inquiries (Armstrong et al., 2004; Ministerial Task Team on Social Health Insurance, 2005; National Department of Health, 1995, 2002; Taylor Committee, 2002) with the most recent being the Health Market Inquiry (Health Market Inquiry (South Africa), 2018).

73. The earlier recommendations resulted in the development of a risk equalisation framework which was due for implementation in 2008 after operating a test framework for a number of years. However, implementation was halted as consideration was instead given to proposals for NHI which have however never been implemented and, as discussed later in this report, are unlikely to have a material impact on the health system for the foreseeable future.

74. The failure to implement a risk equalisation mechanism has harmed efficient competition and contributed to rising healthcare costs with negative implications for access to coverage (Armstrong et al., 2004; Competition Commission, 2019).

Figure 6: **Age distribution by open medical scheme for 2016 compared to the average for all open schemes**



Source: (Council for Medical Schemes, 1980 to 2016)

PUBLIC HEALTH SYSTEM PERFORMANCE FAILURES AND THEIR CAUSES

75. In this section an assessment is provided of the public health system I recently published in a chapter of the book “Epidemics and Healthcare Systems in Africa” in which I assessed the capabilities of South Africa’s health system (van den Heever, 2019).

76. This involved the use of three proxy indicators of performance.

    76.1. South Africa’s facility-based MMRs reflect the maternal deaths per 100,000 live births detected at public health facilities (various sources);

    76.2. The quality assurance assessments of the OHSC (Office of Health Standards Compliance, 2016/17); and

    76.3. The audit outcomes produced by the Auditor General using the latest report of national and provincial performance (Auditor General, 2018).

77. A proxy indicator is an indirect measure that reflects a phenomenon in the absence of a direct measure. The use of proxy indicators is necessary for the South African health system due to weaknesses in output and outcome data attributable to provincial administrations and health facilities. In this instance, the indicator must as far as possible reflect the performance of the organisations concerned and not be contaminated by factors that fall outside the control of the relevant organisations (e.g. socioeconomic factors).

78. While the OHSC and Auditor General analyses are clear indicators of organisational performance, competence and capability, there is always a risk that the outcome indicators, such as mortality ratios, are influenced by factors outside the control of the relevant health departments and facilities. It is important therefore to clarify why MMRs are selected as a proxy health outcome indicator.

79. The assumption that poor facility-based are a proxy measure of general managerial capability rather than just poorly run maternity services is consistent with approaches used in other studies. For instance, similar assumptions were made using *30-day myocardial infarction rates* in competition analyses of public hospital services (see for instance (Cooper, Gibbons, Jones, & McGuire, 2011) where facility-based mortality ratios were used as a general indicator of quality of care and managerial capability in public hospitals in the National Health Service). The assumption is that if these services are poorly run, so are all the others.

Maternal mortality ratios

Benchmark

80. South Africa as a whole compares poorly with comparator countries using MMRs for the year 2015 (**table 3**). Countries against which South Africa should reasonably be compared are reflected in the "Developing country" part of **table 3**. The Industrialised countries" are also shown – and indicate what well-managed healthcare services achieve. A crude average of all the "Developing countries" is indicated as 42.0 in contrast to that for South Africa of 138. Well-managed health systems are expected to achieve MMRs that are less than 10.

Table 3: Maternal Mortality Ratios[18] estimates for South Africa and relevant comparator countries (2015)

Country	MMR	Lower	Upper
Developing countries			
South Africa	**138**	**124**	**154**
Argentina	52	44	63
Brazil	44	36	54
Chile	22	18	26
China	27	22	32
Columbia	64	56	81
Costa Rica	25	20	29
Cuba	39	33	47
Ecuador	64	57	71
El Salvador	54	40	69
Malaysia	40	32	53
Romania	31	22	44
Sri Lanka	30	26	38
Viet Nam	54	41	74
BENCHMARK[19]	**42**		
Industrialised countries			
Australia	6	5	7
Austria	4	3	5
Belgium	7	5	10
Canada	7	5	9
Israel	5	4	6
Netherlands	7	5	9
Spain	5	4	6
United Kingdom	9	8	11
United States of America	14	12	16

[18] These are more comprehensive than facility-based MMRs as they include deaths occurring outside of the facility.

[19] This is based on the average of all the "Developing countries".

Source: International data from (World Health Organisation, 2015, pp. 51-56); Benchmark is calculated and is based on the average of the developing countries

South Africa and provinces – a comparison

81. The provincial breakdown in MMRs indicates that the Western Cape performs consistently better than all the other provinces. It is closest to the benchmark, although in 2017 double the rate (200%) (**figure 7** and **table 4**). While demonstrating some improvement by 2017, Northern Cape performs very poorly with an MMR of 136.8 in comparison to the benchmark of 42.0. This represents a variation from what would be expected of around 325.6%. Gauteng, which experiences the same demographic and socioeconomic challenges as Western Cape is also a consistent poor performer at 306.0% of the benchmark.

82. An important question to ask is why the Western Cape outperforms the other provinces when it faces the same socioeconomic, HIV and AIDS, and other challenges as the other provinces. The Western Cape also receives fiscal allocations consistent with all the other provinces. This suggests that the services are managed more efficiently than all the other provinces. Importantly, this suggests that the MMR is reflecting structural differences in managerial capabilities across the provinces.

83. As a country, the public health services as a whole reflect general poor performance in comparison to peer countries with similar levels of economic development and resource allocations to their public health systems.

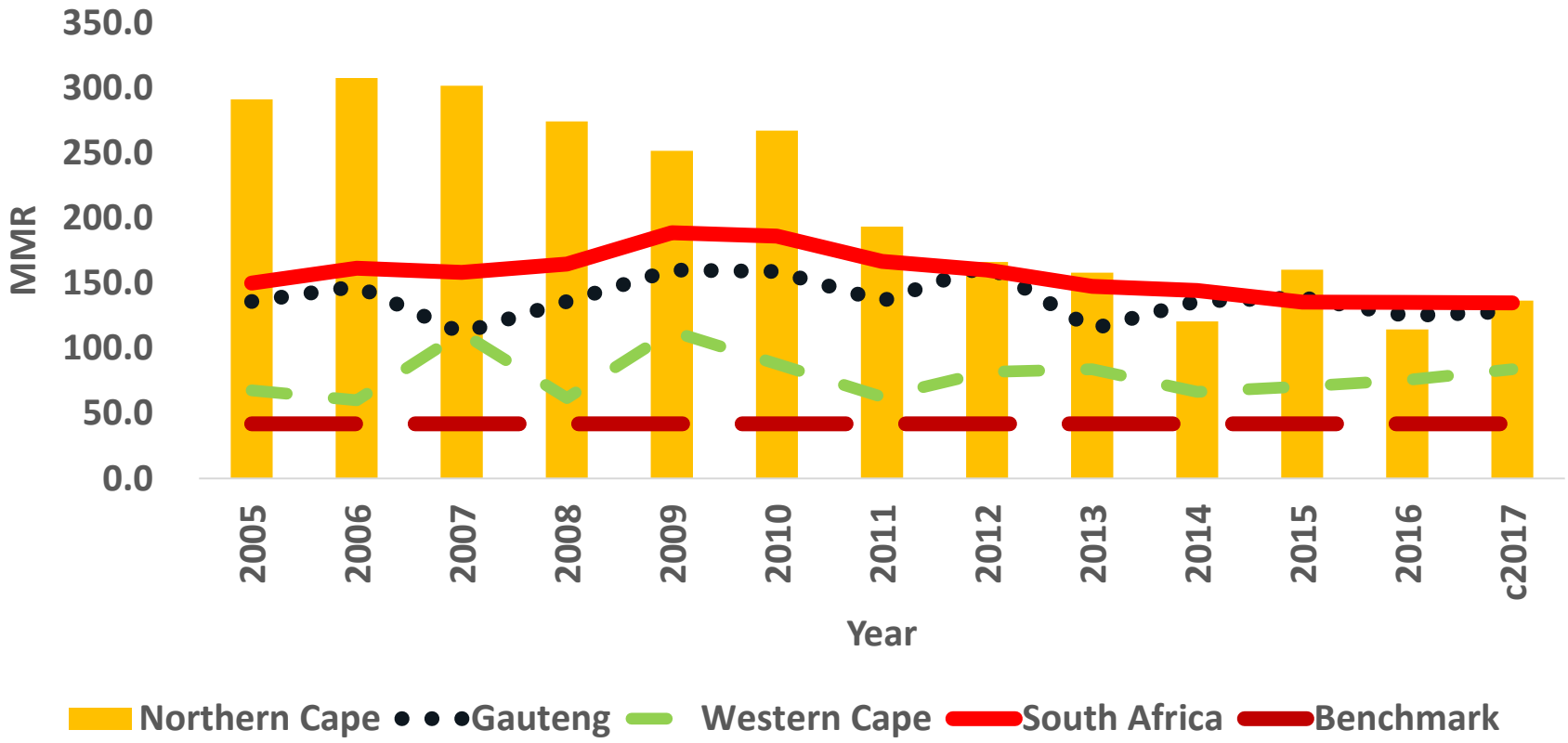
84. Overall, on this indicator, the following is suggested:

    84.1. South Africa has a poorly performing public sector, which cannot be explained purely by the resources allocated to it, as countries at a similar level of development significantly outperform South Africa and all the provinces.

    84.2. The consistent differences in performance between the Western Cape and other provinces suggest that outcomes are the result of systemic factors that influence how the services are managed.

    84.3. When the two provinces of Gauteng and Western Cape, both of which face near identical social, economic and demographic challenges, the structural differences in performance can only be explained by factors such as management capabilities.

Figure 7: **MMRs for selected South African provinces and South Africa contrasted with the Benchmark MMR derived from Table 1**



Sources: South African data (National Department of Health, 2018, p. 4); Benchmark from Table 1 and based on (World Health Organisation, 2015, pp. 51-56)

Table 4: Provincial MMRs for provinces and South Africa compared to the Benchmark MMR derived from Table 1

Province	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016	c2017
Eastern Cape	140.1	131.6	138.7	180.4	215.2	197.0	164.7	153.7	172.7	174.2	133.4	144.1	142.1
Free State	353.8	334.1	313.1	267.0	350.9	263.5	246.8	149.3	185.1	203.3	162.8	172.7	154.9
Gauteng	**136.0**	**147.6**	**111.9**	**136.0**	**160.2**	**159.2**	**136.4**	**163.7**	**115.0**	**136.3**	**139.0**	**125.1**	**128.5**
KwaZulu-Natal	152.6	187.9	181.6	183.8	194.2	208.7	197.6	170.2	146.5	140.9	125.7	124.6	135.7
Limpopo	150.5	167.6	182.9	176.6	160.4	166.7	196.4	192.9	201.2	169.8	168.1	170.7	151.9
Mpumalanga	114.5	151.1	126.7	179.8	159.4	218.6	199.7	177.4	150.3	119.5	136.5	148.5	156.0
North West	174.2	144.2	121.2	161.7	279.5	256.1	173.0	164.8	168.5	200.9	168.0	152.0	150.2
Northern Cape	**291.4**	**307.9**	**301.8**	**274.4**	**251.8**	**267.4**	**193.6**	**166.5**	**158.3**	**120.7**	**160.5**	**114.5**	**136.8**
Western Cape	**67.7**	**60.1**	**112.0**	**61.8**	**113.1**	**88.0**	**62.6**	**81.8**	**83.9**	**66.5**	**70.6**	**75.8**	**84.0**
South Africa	**150.2**	**161.7**	**158.5**	**164.8**	**188.9**	**186.2**	**167.0**	**160.2**	**147.7**	**144.6**	**135.5**	**135.3**	**135.0**
Benchmark	**42.0**	**42.0**	**42.0**	**42.0**	**42.0**	**42.0**	**42.0**	**42.0**	**42.0**	**42.0**	**42.0**	**42.0**	**42.0**
MMR for South Africa and selected provinces expressed as a percentage of the benchmark (%)													
South Africa	357.6	385.0	377.4	392.4	449.8	443.3	397.5	381.5	351.6	344.2	322.7	322.1	321.4
Northern Cape	693.8	733.1	718.6	653.3	599.5	636.7	461.0	396.4	376.9	287.3	382.2	272.6	325.6
Western Cape	161.2	143.1	266.7	147.1	269.3	209.5	149.0	194.8	199.8	158.3	168.1	180.4	200.0
Gauteng	323.8	351.4	266.4	323.8	381.4	379.0	324.8	389.8	273.8	324.4	330.9	297.8	306.0

Sources: South African data (National Department of Health, 2018, p. 4); Benchmark from table 5 and based on (World Health Organisation, 2015, pp. 51-56)

84.4. The Northern Cape, consistent with all the provinces other than the Western Cape, performs very poorly relative to both the benchmark and the Western Cape. This is indicative of general poor management.

Office of Health Standards Compliance

85. The OHSC attempts to assess the quality assurance features in place within facilities. To date it has focused exclusively on public facilities. The functions of the OHSC include:

> *"… [m]onitoring and enforcing compliance by health establishments with norms and standards prescribed by the Minister of Health in relation to the national health system"; and "[e]nsuring consideration, investigation and disposal of complaints relating to non-compliance with prescribed norms and standards for health establishments in a procedurally fair, economical and expeditious manner." "The term health establishment refers to both public and private healthcare services and facilities … . It includes hospitals and primary healthcare clinics and extends to emergency medical services, hospices, private medical practices and institutions offering frail care."* (Office of Health Standards Compliance, 2018)

86. To assess capabilities of the South African health system the data from the 2016/17 audit of the OHSC has been weighted provincially using hospital bed data provided by the NDOH (National Department of Health, 2013). The results are shown in **table 5**. A scatter diagramme of the two series is presented in **figure 8**.

87. The results demonstrate some inconsistencies and some consistencies. On the one hand the Western Cape scores well on both indices, with both the lowest MMR and the highest weighted average quality assurance score. This is consistent with the conclusion that a well-managed department will score well in both instances.

88. Also consistent with this logic, provinces scoring poorly on their MMRs also score poorly on their quality assurance assessment. Provinces falling into this group include: Northern Cape (the worst performer on quality assurance), Mpumalanga, Eastern Cape, Limpopo and Free State.

89. Apparently inconsistent with this logic, three provinces score relatively high on quality assurance but poorly on outcomes (MMR). These are North West, Kwazulu-Natal and

Gauteng. However, this result would be consistent with facilities at least meeting some basic quality assurance measures, without necessarily improving their services.

90. Overall only seven health establishments out of 696 public health facilities managed to achieve the 80% score required for accreditation by the OHSC (Office of Health Standards Compliance, 2016/17, p. 31).

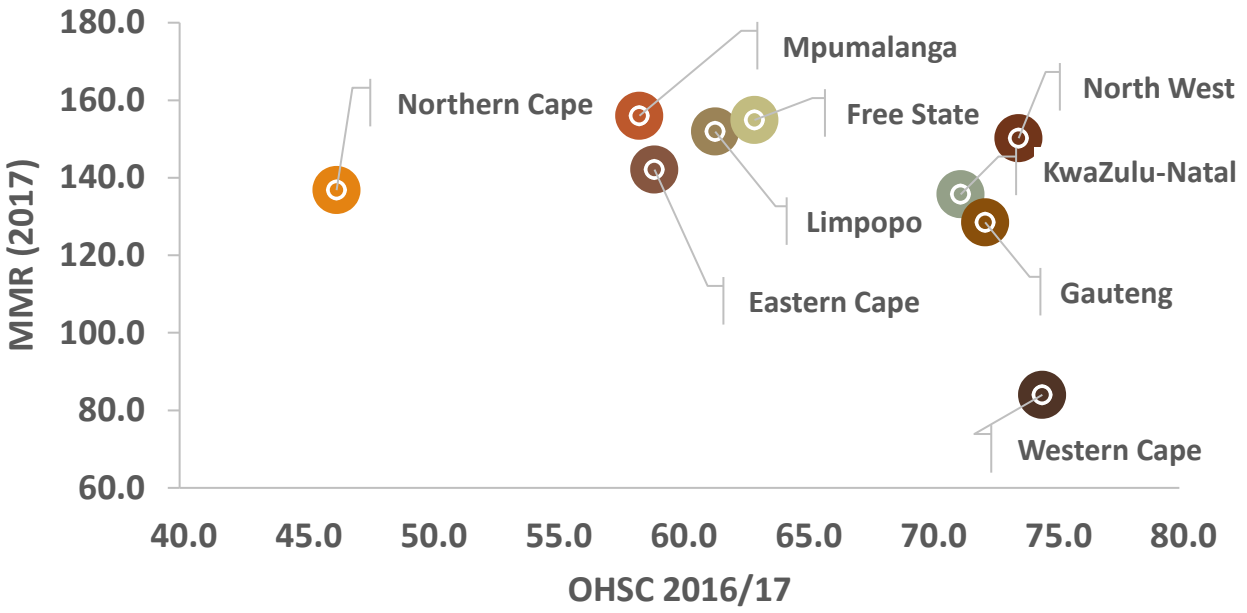
Table 5: Office of Health Standards Compliance weighted average score for public hospitals by province (2016/17) compared to the MMR (2017)

Province	Weighted average quality score from the OHSC (2016/17) (highest score = 100) (benchmark = 80)	MMR (2010-12)
Western Cape	74.52	84.0
Gauteng	72.23	128.5
Eastern Cape	59.00	142.1
North West	73.57	150.2
Limpopo	61.43	151.9
KwaZulu-Natal	71.25	135.7
Mpumalanga	58.40	156.0
Northern Cape	46.28	136.8
Free State	63.00	154.9

Source: OHSC data based on (Office of Health Standards Compliance, 2016/17). The MMR data is from **table 4** and repeated for comparison with the OHSC. Usable public hospital bed data by province was sourced from the NDOH.

91. It is important to note that the benchmark score for compliance with the OHSC norms is 80%. Unfortunately, no province meets this standard. Therefore, although the Western Cape clearly outperforms the other provinces, it does not meet the benchmarks for either the MMR or the OHSC indicators.

Figure 8: OHSC weighted average score for public hospitals by province (2016/17) compared to the MMR (2017)



Source: Data from **table 5**.

92. Overall the findings from this review are:

    92.1. The OHSC appears to be a valid indicator of managerial capability within the provincial hospital services. However, it demonstrates a weakness in some provinces where they may have sufficient managerial capacity to achieve better scores on the OHSC indicator while still not being able to achieve the more difficult objective of better health outcomes (indicated by the MMR).

    92.2. Northern Cape is a poor performer on both the OHSC and MMR indicator. This would suggest significant weaknesses in managerial capabilities relative to other provinces.

Auditor General's findings

93. The most recently published Auditor General's findings for provincial governments is both revealing and disturbing. **Table 6** provides the audit findings for the provincial governments as a whole for 2016/17 (Auditor General, 2018).

94. The 'clean audit' results ('where the financial statements are free from material misstatements and there are no material findings on reporting on performance objectives or non-compliance

with legislation' (Auditor General of South Africa, 2012, p. 4)) by province are broadly consistent with the MMR and the OHSC results.

95. The Western Cape achieves an 83% result, with the next nearest province Gauteng at a relatively poor 52 percent.

96. No other province achieves more than 24 percent. Irregular expenditure also stands at a relatively minor R44 million for Western Cape while the other provinces range from R860 million to R9.917 billion.

97. Although these results are not health department-specific, they suggest that the management weaknesses are influenced by governance at the wider provincial level. Free State, KwaZulu-Natal and North West all have irregular expenditure in excess of 8% of their levels of expenditure – at 11.9%, 9.0% and 8.2% respectively. Northern Cape also demonstrates an unusual level of irregular expenditure at 6.7% of total expenditure.

98. When the Auditor General compared the financial health of the health and education with other departments it is clear that while both health and education perform poorly (i.e. the bulk of provincial expenditure), health departments stand out as the worst performing.

99. Overall only one health and one education department achieve a 'good' result (both in the Western Cape), defined as having fewer than 30% unfavourable indicators. For health departments 37% raise concerns, and 50% require an intervention. Other departments achieve a 'good' result in 42% of cases with 8% requiring an intervention. The Auditor General in fact notes that urgent action is required to prevent a collapse of health services.

> *"The financial health of provincial departments of health and education needs urgent intervention to prevent the collapse of these key service delivery departments. In comparison with the other departments, these sectors (particularly the health sector) are in a bad state, …"* (Auditor General, 2018: 76).

This view is now quite widely reflected (Dhai & Mahomed, 2018).

Table 6: Overview of findings by province (2016/17)

Province	Clean audits (%)	Financially unqualified financial statements (%)	No findings on performance reports (%)	No findings on compliance with legislation (%)	Irregular expenditure with the percentage of expenditure in brackets
Western Cape	**83**	**94**	**89**	**94**	**R44 million (0.1%)**
Gauteng	52	100	68	57	R6.367 billion (5.9%)
Mpumalanga	24	76	71	24	R2.218 billion (5.3%)
Northern Cape	23	85	69	23	R1.050 billion (6.7%)
Eastern Cape	19	86	57	19	R860 million (1.2%)
Free State	13	47	36	0	R3.860 billion (11.9%)
KwaZulu-Natal	12	79	64	12	R9.917 billion (9.0%)
North West	5	37	35	5	R3.065 billion (8.2%)
Limpopo	5	60	45	10	R2.471 billion (4.1%)

Source: (Auditor General, 2018; National Treasury, 2018b)

Table 7: Financial health and unauthorised expenditure for health, education and other departments at a provincial level (number of departments relevant to the outcome in brackets)

Departments	Good	Of concern	Intervention required
Health departments	13% (1)	37% (3)	50% (4)
Education departments	11% (1)	78% (7)	11% (1)
Other departments	42% (60)	50% (72)	8% (12)

Source: (Auditor General, 2018, p. 76)

Note: Explanation of headings in Table 7:

Good	Fewer than 30% unfavourable indicators
Of concern	30% or more unfavourable indicators
Intervention required	Significant doubt that can continue in future (vulnerable position) and/or where auditees received a disclaimed or adverse opinion, which meant that the financial statements were not reliable enough for analysis

Source: (Auditor General, 2018, p. 72)

100. The overall findings are as follows:

100.1. The Auditor General's findings with respect to both provincial governments as a whole and health expenditure are consistent with the view that the public health system is in crisis.

100.2. Consistent with the MMR and OHSC indicators, the Western Cape stands out as relatively well-performing outlier. This is strongly suggestive of a generally well-performing province that is reflected in all the indicators used.

100.3. The Northern Cape again stands out as a poor performer. While irregular expenditure is expressed at a provincial level, health care is one of the two major functions carried out at a provincial level. It can reasonably be assumed that a poorly performing provincial administration will result in a poorly performing health department.

Discussion

101. All three sets of indicators presented in this section support a finding that the public health system is generally poorly managed and is operating below its potential. The health outcome indicator, in the form of facility-based MMRs directly implicate the health services rather than wider socioeconomic factors, as the source of higher than normal mortality.

102. Countries of a similar level of development to South Africa and with comparable or lower levels of fiscal support for public health services achieve better MMR results (also see (Development Bank of South Africa, 2008, pp. 16-17)).

103. There is no evidence that suggests that South Africa's public health services are systematically improving. Furthermore, there are publicly expressed concerns that the health system is in crisis and calls for serious intervention both from a governance and finance perspective.

104. In December 2018 the Lancet Commission reporting to the Minister of Health in South Africa made the following findings:

104.1. "*Finding 1 Poor people, especially in rural areas and particularly those with certain health conditions such as mental illness, bear the brunt of poor quality care.*"

104.2. "*Finding 2 In the 2016-2017 financial year, the Auditor-General reported that litigation and claims in the public health sector amounted to more than R1.2 billion, thus placing a huge burden on the distressed health system and reducing financial*

resources available for health service provision. In the private health sector, the long-term average claim frequency for doctors was 27% higher in 2015 compared to 2009."

104.3. "*Finding 3 Notwithstanding the enabling Constitution, strong health legislation and numerous health policies that express Government's commitment to a high quality health system, failures in ethical leadership, management and governance contribute to the poor quality of care. These failures are exacerbated by evidence of mismanagement, inefficiencies and incompetence at all levels of the health system*."

104.4. "*Finding 4 Corruption and fraud are major threats to equitable access to quality health care*."

104.5. "*Finding 5 The human resources for health crisis characterised by: staff shortages, inequities and mal-distribution between urban and rural areas and between the public and private health sectors; unprofessional behaviour, and poor staff motivation and performance, will undermine the achievement of high quality universal health coverage*."

104.6. "*Finding 6 Quality of care indicators focus primarily on structure, process and outputs in both the public and private health sectors. Data quality remains a significant barrier to the assessment of health system performance on the quality of care provided*."

104.7. "*Finding 7 Although there are numerous encouraging quality improvement initiatives in South Africa, the impact is limited because of fragmentation across health conditions, levels of care and between the public and private health sectors. This is exacerbated by suboptimal implementation of the results of quality audits, especially in the public health sector*."

105. A major contributing factor to the poor performance of the public health system are the weak governance frameworks that foster inefficiencies through corruption and nepotism. These failures have also been surveyed in peer reviewed articles on the South African public health system and draw a clear connection between systematic failures in performance and governance weaknesses that expose health departments to corruption (Laetitia C Rispel, de Jager, & Fonn, 2015).

106. The stark differences noted between the performance of the Western Cape Province and all the others is also indicative of a clear difference in conduct with respect to governance.

PART 3: EVALUATION OF THE NATIONAL HEALTH INSURANCE PROPOSALS

This part offers a critical review of the substance of the NHI proposals. The focus is principally strategic in nature. This is because many of the details contained in the NHIB and in the policy framework flow from the strategic features. The details matter on insofar as the strategic elements make sense.

THE NATIONAL HEALTH INSURANCE BILL

107. The NHIB was submitted to Parliament on 26 July 2019. Ostensibly the NHIB focuses on the establishment of an organisation referred to as the National Health Insurance Fund (NHIF).

108. Two broad features characterise the NHI policy proposal.

    108.1. The first is to achieve the nation-wide "pooling" of resources for health the through consolidation of all relevant cross-subsidies for healthcare in a single scheme, the NHIF.

    108.2. The second is to consolidate the purchasing of healthcare into a single scheme, the NHIF.

109. The purpose of the NHIF is to *purchase* all needed healthcare for all residents of South Africa.

110. The term "purchase" is meant to be understood in a literal sense – by which is meant "to procure" healthcare goods and services.

111. The envisaged institutional framework therefore establishes only one mechanism by which Government will guarantee formal system of social protection for access to healthcare. That is the healthcare *purchased* by the NHIF.

112. Therefore, to the extent that other forms of healthcare coverage may continue to exist, it is the purpose of this legislative framework that protection as envisaged by section 27 of the Bill of Rights (Republic of South Africa, 1996b) will not be offered statutory protection of coverage.

113. The legislative framework in fact goes so far as to prohibit alternative forms of coverage through medical schemes and other social insurance arrangements.[20]

114. The NHIB nevertheless states that "a user", by which is meant every resident, has a right "… to purchase health care services that are not covered by the Fund through a complementary voluntary medical insurance scheme registered in terms of the Medical Schemes Act, any other private health insurance scheme or out of pocket payments, as the case may be." (Minister of Health, 2019, pp., section 6(o))

[20] These provisions can be found in section 33, which deals with the role of medical schemes, and in the schedule that deals with the repeal and amendment of legislation affected by the Act (section 58). Section 58 repeals coverage provided through the Occupational Diseases and Works Act of 1973, the Compensation for Occupational Injuries and Diseases Act of 1993, the Road Accident Fund Act of 1996, the Correctional Services Act of 1998 and the Medical Schemes Act of 1998.

115. While it is unclear what "*not covered*" really means, assuming clarity emerges, "users" will not be permitted to even purchase out-of-pocket services that are covered by the NHIF.

116. The provision also implies that medical schemes will always remain voluntary, despite the recent recommendations of the Health Market Inquiry (HMI) that they should ultimately become mandatory.

> "*In principle, we agree that mandatory membership will address anti-selection. However, before mandatory cover is introduced, the industry needs to show clear indications of closer alignment to consumer interests and better cost containment. We have not recommended mandatory membership at this point but believe that at a future date it would be appropriate*." (Competition Commission, 2019, pp., par 43)

117. Effectively, all other possible areas of formal health-related social protection will be *dispensed with*. In other words, all instances of statutory protection for access to health services falling outside of the NHIF will be removed.

118. The function "*purchasing*" is seen as distinct from the function of, for instance, healthcare "provision". In this way health services, whether public or private, will be seen as separate legal entities from the purchaser. This is referred to as a "purchaser-provider split", which is regarded in the proposals as the *central efficiency-inducing* feature of the NHI framework.[21]

> "*The NHI Fund will use its various payment mechanisms to leverage the provision of efficient and quality services through linking provider payment to their performance and compliance with accreditation criteria. The reimbursement system will be regularly reviewed and refined taking into account implementation experiences and budget impact assessments*." (National Department of Health, 2017, par 289)

119. While the system of medical schemes already operates along these lines (i.e. it is characterised as having a purchaser-provider split), this is not the historical practice of the public sector services, which operate entirely on budget allocations made available by provincial departments of health.

[21] The Memorandum on the Objects of the NHIB indicates that the proposals are intended to address, inter alia, "…inefficient provider payment mechanisms in both the public and private sectors." (Minister of Health, 2019, p. 47)

120. Public healthcare services legally form part of the (provincial) *administration* that supervises their operations and organises their funding. Simply stated, the functions of purchasing and provision are not separate and are often referred to as *vertically integrated* by economists.

121. The rationale behind this separation into *purchasing* and *provision* is to achieve efficiencies through the establishment of a *dominant purchaser* that will be able to engineer efficient arrangements with providers through "*strategic contracts*". It is presently assumed that the combination of scale together with purchasing power will induce these efficient contracts.

122. While concepts such as equality and equity are extraordinarily complex, when considered in relation to any practical question of policy, no express logic has been presented with respect to the NHI proposals. By constantly referencing differences in per-capita expenditure between public sector users and medical scheme members it is implied that any differences in expenditure reflect inequity.

123. The implied equity objectives are to be achieved through compelling all "users" (i.e. everyone) to be part of one scheme. This, it is implied, eliminates the different (higher) levels of expenditure resulting from households purchasing healthcare, using their disposable income, outside of the public system using medical scheme coverage.

124. It is important to note that medical scheme members are in fact presently denied free access to public hospital services. Without medical scheme coverage they would face severe prejudice, even were they to attempt to access a public facility. Furthermore, provincial health departments receive revenue in terms of the PES exclusively for public sector populations, as medical schemes populations are removed from the revenue distribution formula.

125. It is for this reason that provincial governments charge for medical scheme members. However, this framework has the further consequence that public health service investments do not cater for medical scheme members, as they are assumed to be catered for by private hospitals.

MAIN FEATURES OF THE NATIONAL HEALTH INSURANCE BILL

126. As already noted, the NHI framework envisages the establishment of a single organisation to purchase all needed healthcare in South Africa. To this end, the following is envisaged:

126.1. All revenue that would have been allocated via the PES and conditional grants will now be re-directed to the NHIF (indicated in red in **figure 9**). Provincial governments will therefore not receive transfers from national government to carry out their Constitutional obligations with respect to healthcare. In effect, provincial departments will become agents of the NHIF.

126.2. As control over financing also implies control over service planning, i.e. the spatial distribution and mix of health services, effectively provincial health administrations would for all practical purposes cease to play this role. Accordingly "*health services*" would cease to be a concurrent function between national and provincial governments – nullifying the Constitutional allocation of functions.

126.3. Provincial health services would furthermore not receive financing for healthcare as revenue for further appropriation by provincial legislatures. Instead, it would appear, that provincial health services would receive revenue in the form of health service reimbursements – much the way private health services receive them. *Technically this means that national government appropriates the funds for the NHIF, which then buys either provincial or private health services*.

126.4. The current subsidy for medical schemes would also be removed and re-directed to the NHIF (the "TES" or tax expenditure subsidy shown in red in **figure 9**). The removal of this subsidy would have the immediate implication that lower-income medical scheme members (typically pensioners) will have to drop their coverage and try to access coverage through provincial administrations.

126.5. The NHI framework also envisages the removal of the system of mandatory minimum benefits which medical schemes must cover (the system of benefit access guarantees shown in red in **figure 9**). The existing framework prevents medical schemes from structuring their coverage to exclude people with pre-existing medical conditions or who have poor health status (generally older people).

126.6. Not included in **figure 9** is the removal of protected coverage via entities such as the Road Accident Fund and the Compensation for Accidents and Injuries on Duty. These have been noted earlier in this report.

126.7. The ultimate framework, implied by the NHIB, is that general taxes would be increased at least equivalent to the absolute values of what medical scheme members were contributing voluntarily for their own coverage. This would amount to around 3.5% of GDP – or higher.

126.8. The overall framework is presented in **figure 10**, which illustrates that one monopoly public structure would now purchase all needed healthcare goods and services in South Africa. It is suggested in the various supporting documents that the NHIF would make the services compete for contracts.

126.9. The corporate governance model for the NHIF is a political one, i.e. all appointments (the board and the chief executive officer (CEO)) are directly or indirectly made by the Minister of Health. The Minister of Health also appoints the board and executive of the OHSC, which is responsible for accrediting health providers. Where health providers do not receive accreditation, it is suggested that they will not be able to contract with the NHIF.

126.10. It is worth noting, that presently all regulatory bodies involve political appointments by the Minister of Health.

126.11. Within the NHIF, the Minister of Health is allocated substantial additional powers. The following instances involving procurement decisions are noteworthy:

126.11.1. "The Fund, in consultation with the Minister, must purchase health care services, determined by the Benefits Advisory Committee…" (Minister of Health, 2019, (section 4(1)))

126.11.2. "Subject to the provisions of this Act, the Fund, in consultation with the Minister, must purchase health care services, determined by the Benefits Advisory Committee, for the benefit of users." (Minister of Health, 2019, (section 7(1))

126.11.3. "Treatment must not be funded if a health care service provider demonstrates that— … the health care product or treatment is not included in the Formulary, except in circumstances where a

complementary list has been approved by the Minister." (Minister of Health, 2019, section 7(4)(c))

126.11.4. "The Fund performs its functions in accordance with health policies approved by the Minister." (Minister of Health, 2019, section 10(3))

126.11.5. "The Fund must support the Minister in fulfilling his or her obligation to protect, promote, improve and maintain the health of the population as provided for in section 3 of the National Health Act." (Minister of Health, 2019, section 10(4))

126.11.6. "identify, develop, promote and facilitate the implementation of best practices in respect of— … the design of the health care service benefits to be purchased by the Fund, in consultation with the Minister …" (Minister of Health, 2019, section 11(1)(vii))

126.11.7. "identify, develop, promote and facilitate the implementation of best practices in respect of— … referral networks in respect of users, in consultation with the Minister …" (Minister of Health, 2019, section 11(1)(viii))

126.11.8. "A Board that is accountable to the Minister is hereby established to govern the Fund in accordance with the provisions of the Public Finance Management Act." (Minister of Health, 2019, section 12)

126.11.9. "The Board consists of not more than 11 persons appointed by the Minister who are not employed by the Fund and one member who represents the Minister." (Minister of Health, 2019, section 13(1))

126.11.10. "Before the Board members contemplated in subsection (1) are appointed, the Minister must issue in the Gazette a call for the public nomination of candidates to serve on the Board." (Minister of Health, 2019, section 13(2))

126.11.11. "An ad hoc advisory panel appointed by the Minister must— (a) conduct public interviews of shortlisted candidates; and (b) forward their recommendations to the Minister for approval." (Minister of Health, 2019, section 13(3))

126.11.12. "The Minister may remove a Board member if that person—

126.11.13. *(a) is or becomes disqualified in terms of any law; (b) fails to perform the functions of office in good faith, in the public interest and in accordance with applicable ethical and legal prescripts; or (c) becomes unable to continue to perform the functions of office for any other reason." (Minister of Health, 2019, section 13(8))*

126.11.14. *"(a) Subject to paragraph (b), the Minister may dissolve the Board on good cause shown only after— (i) giving the Board a reasonable opportunity to make representations; and (ii) affording the Board a hearing on any representations received. (b) If the Minister dissolves the Board in terms of this subsection, the Minister— (i) may appoint acting Board members for a maximum period of three months to do anything required by this Act, subject to any conditions that the Minister may require; and (ii) must, as soon as is feasible, but not later than three months after the dissolution of the Board, replace the Board members in the same manner that they were appointed in terms of this section." (Minister of Health, 2019, section 13(9))*

126.11.15. *"The Minister must appoint a Chairperson from amongst the members of the Board as contemplated in section 13(1)." (Minister of Health, 2019, section 14(1))*

126.11.16. *"The Board must fulfil the functions of an accounting authority as required by the Public Finance Management Act and is accountable to the Minister." (Minister of Health, 2019, section 15(1))*

126.11.17. *"The Board must determine its own procedures in consultation with the Minister." (Minister of Health, 2019, section 17)*

126.11.18. *"The Fund may remunerate a Board member and compensate him or her for expenses as determined by the Minister in consultation with the Minister of Finance and in line with the provisions of the Public Finance Management Act." (Minister of Health, 2019, section 18)*

126.11.19. *In appointing CEO "The Board must— (a) conduct interviews of shortlisted candidates; and (b) forward their recommendations to the Minister for approval by Cabinet." (Minister of Health, 2019, section 19(2))*

126.11.20. *"A person appointed as Chief Executive Officer holds office— (a) for an agreed term not exceeding five years, which is renewable only once; and (b) subject to the directives and determinations of the Board in consultation with the Minister." (Minister of Health, 2019, section 19(4))*

126.11.21. *"The Board may recommend to the Minister the removal of the Chief Executive Officer if that person— (a) is or becomes disqualified in terms of the law; (b) fails to perform the functions of his or her office in good faith, in the public interest and in accordance with applicable ethical and legal prescripts; or (c) becomes unable to continue to perform the functions of his or her office for any other reason." (Minister of Health, 2019section 19(5))*

126.11.22. *"(1) The Chief Executive Officer of the Fund must meet with the Minister, Director-General of Health and the Chief Executive Officer of the Office of Health Standards Compliance at least four times per year in order to exchange information necessary for him or her to carry out his or her responsibilities. (2) Notwithstanding subsection (1) the Chief Executive Officer remains accountable to the Board." (Minister of Health, 2019, section 21)*

126.11.23. *Advisory committees appointed by the Minister (after consultation with the NHIF board): benefits advisory committee; the healthcare benefits pricing committee; the stakeholder advisory committee. (Minister of Health, 2019, chapter 7)*

126.11.24. *"(1) The Board, in consultation with the Minister, must establish an Office of Health Products Procurement which sets parameters for the public procurement of health related products. (2) The Office of Health Products Procurement must be located within the Fund and is responsible for the centralised facilitation and coordination of functions related to the public procurement of health related products, including but not limited to medicines, medical devices and equipment." (Minister of Health, 2019, section 38)*

126.11.25. *"The Fund, in consultation with the Minister, must determine the nature of provider payment mechanisms and adopt additional mechanisms." (Minister of Health, 2019, section 41(1))*

126.11.26. *"An affected natural or juristic person, namely a user, health care service provider, health establishment or supplier, may furnish a complaint with the Fund in terms of the procedures determined by the Fund in consultation with the Minister, and the Fund must deal with such complaints in a timeous manner and in terms of the law." (Minister of Health, 2019, section 42(1))*

126.11.27. *"An Appeal Tribunal is hereby established, consisting of five persons appointed by the Minister…" (Minister of Health, 2019, section 44(1))*

126.11.28. *"The Minister, in consultation with the Minister of Finance and the Fund, must determine the terms, conditions, remuneration and allowances applicable to the members of the Appeal Tribunal." (Minister of Health, 2019, section 47(1))*

126.11.29. *"A member of the Appeal Tribunal must recuse himself or herself if it transpires that he or she has any direct or indirect personal interest in the outcome of the appeal and must be replaced for the duration of the hearing by another person with similar knowledge appointed by the Minister." (Minister of Health, 2019, section 47(2))*

127. The organisation of the NHIF is loosely framed in the NHIB, with references made to the establishment of sub-structures of national government.

127.1. The establishment of District Health Management Offices (DHMO) through amendment to the National Health Act. These are established as "*national government components*". These structures effectively strip away the powers of provinces to finance, plan and district health services and allocate them to the Minister of Health.

127.2. Amendments to the National Health Act further stipulate that the DHMOs must establish contracting units, which will receive funds, determined by a formula, from the NHIF to contract with primary care providers. These contracting units, established as part of DHMOs, will be required to contract with the NHIF to receive funds from the NHIF.

128. Government components are structures that can be established in terms of the Public Service Act of 2007 (Minister of Public Service Administration, 2007). These are loosely described structures that can be established by an executive authority (a national minister or a member of the executive council in the case of provinces) to which wide duties can be assigned by the relevant executive authority.

129. A government component is effectively a department within a department, whereby the head of a component can be an accounting officer in terms of the Public Finance Management Act. The executive authority can delegate any of their powers (apart from the powers to regulate) to a component.

130. A government component can only be established if the "prescribed feasibility study is conducted and its findings recommend the establishment of such a component." (Minister of Public Service Administration, 2007, section 10(7A)(1)). No evidence of such a feasibility could be found, however, apart from the appraisal of the 11 NHI pilots, which did not test health authority designs or the implications of wide delegations allocated to public entities.

131. The NHIB and the proposed amendments to the National Health Act do not provide a complete governance framework for the components, it essentially establishes a set of national structures that will be appointed by the Minister of Health and directly report to that office. No framework is established that makes the proposed DHMOs accountable to the communities they will purchase services for. There is also no clarification of what kind of public structure a so-called contracting unit is. Given that they would have substantial delegated powers to procure health services, this is concerning.

132. It is also quite unclear why the NHIB references another piece of legislation to establish an organisation structure. A piece of national legislation should be used to establish custom-designed health authorities <u>together with clearly specified features in the principal legislation</u>. These would include (inter alia): corporate governance design; the powers of supervisory and executive officers; nomination, appointment and removal frameworks of supervisory boards and executive officers; the jurisdiction of the organisation; reporting lines; conflict resolution procedures; financing framework; etc..

Figure 9: Proposed changes to the UHC framework to implement the NHI framework

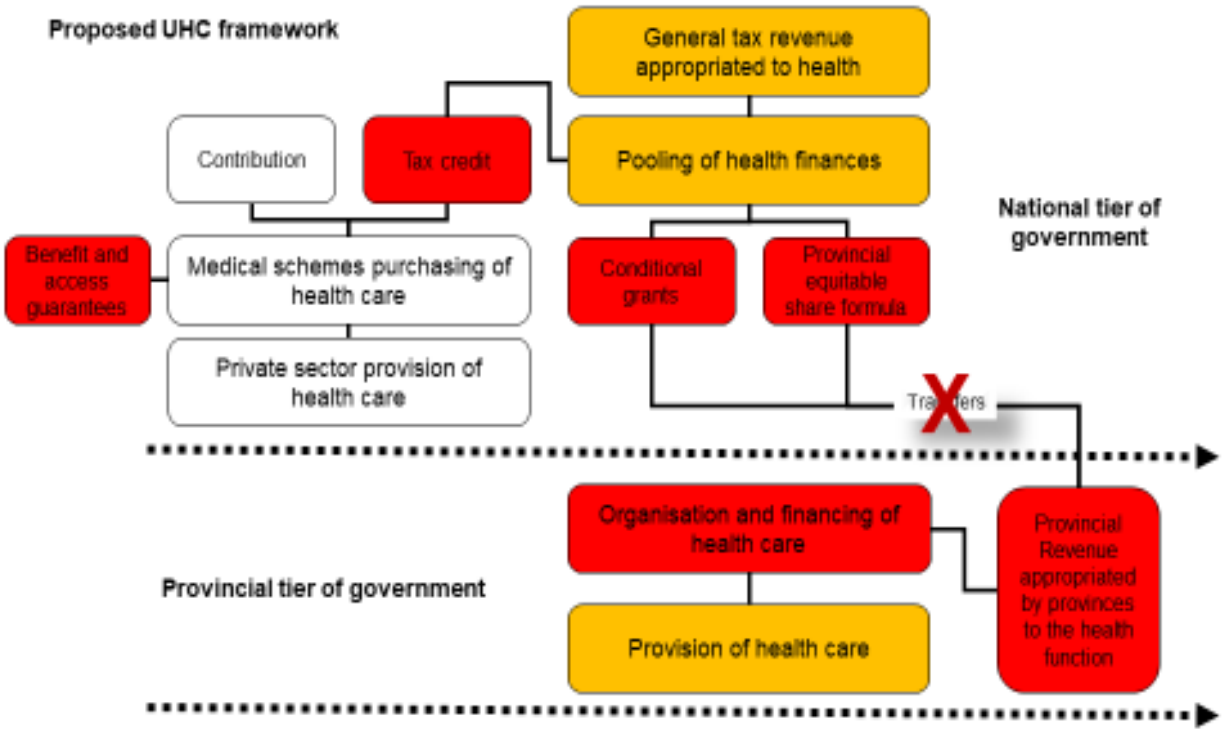
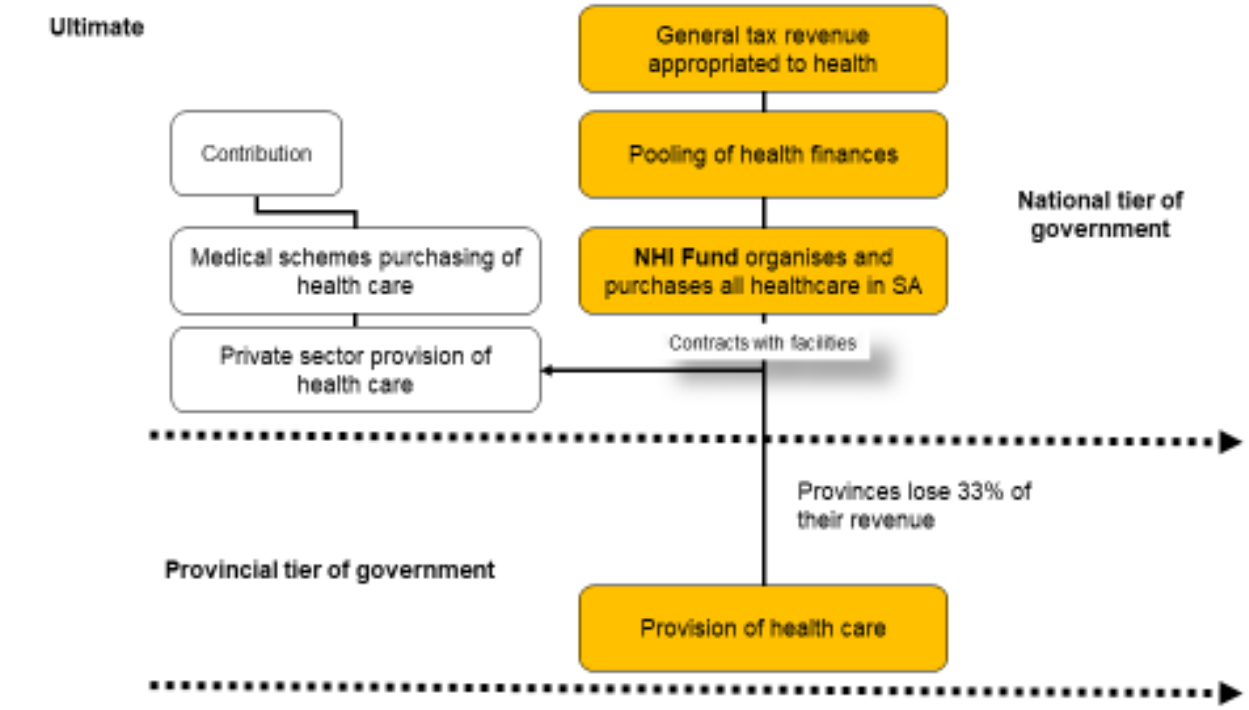


Figure 10: Proposed NHI framework



133. *The framework dealing with the DHMOs and primary contracting units[22] need to be abandoned in total and replaced with a national framework for regional and district authorities at the provincial level. This would be consistent with the Constitutional role of national government in relation to provincial health services as a national framework would have been established, that would not involve the centralisation of functions that should properly be managed at a level of government that is closer to the ground*.

[22] It is noted that the idea for these contracting units was borrowed from operational structures from the Thailand universal coverage scheme. This is, however, an artificial adoption of a institutional construct that may have more relevance in another context.

EXAMINATION OF THE STATED RATIONALE FOR NATIONAL HEALTH INSURANCE

134. The stated rationale for the NHI framework is offered in the Memorandum of Objectives provided in the NHI Bill (Minister of Health, 2019). It is important to note that any policy proposal requires a clear identification of the problem that motivates it. And, importantly, the problem should be one that is appropriate for a government to step in, i.e. not all problems require government action.

135. A feature of the NHI process has been the number of official actors who have offered various rationales for the proposed NHI framework, not all of which are laid out in the official documentation. As official actors form part of the process of motivating public support for the NHI framework, both documented official rationales and public statements by official representatives of the NHI process need to be reviewed and are therefore discussed below.

136. In a democracy, public policy formation and implementation is not an arbitrary discretion of any political party, government or set of public officials. Elections do not confer blanket rights on any person to make policy as they please. Instead, policy must be justified on the basis that it addresses a genuine public concern and be implemented in a manner that reasonably addresses any identified public concern. This understanding of democracy is laid out clearly in the Constitution of South Africa (Republic of South Africa, 1996b).

137. Furthermore, within the South Africa context, an obligation is placed on an elected government to actively investigate and consider policies that promote the interests of the country. It is furthermore not the role of any elected government to use the powers of Government to promote private interests of any form at the cost of the public interest. In other words, no discretion of any form allocated to an office of Government can be rationally interpreted to permit the pursuit of private over the public interest.

138. An important feature of any rationale, therefore, is the evidence upon which it is based. It is plainly not rational for a policy to be justified purely on the basis of vague sweeping statements and unfounded generalisations. Nor can it be justified on the grounds of an exercise of some blanket discretion.

139. It is with the above in mind that the following three questions need to be addressed relating to the NHI proposals, *together with supporting evidence and coherent arguments*:

    139.1. First, what is the public problem that needs to be addressed?

    139.2. Second, what is the appropriate role of government in addressing the problem?

139.3. Third, what policies are required to address the identified problem?

140. The extent and nature of any evidence required to motivate any particular policy will vary in accordance with the policy context, the scale of any proposed intervention, the risks posed to any part of the population and the fairness of any proposals. In most instances the requirement for evidence will logically present itself. The requirement for strong evidence in relation to all aspects of the NHI policy proposals are self-evident. The extent to which evidence has informed the proposals are discussed below.

Documented rationales

141. The memorandum on the objects of the NHIB (Minister of Health, 2019) outlines two principal rationales for the NHI framework:

> "*There is a need for reform of both the health care financing and service delivery systems so that all South Africans have access to affordable, quality personal health care services regardless of their socioeconomic status within the context of the burden of disease in South Africa*." (Minister of Health, 2019, par 2.1.1)
>
> "*The main problem relates to the fragmentation of health care fund pools in the South African health system and the aim is to create an integrated pool in order to achieve universal health coverage for health care services by establishing a purchaser-provider split with the Fund being the single-payer for comprehensive health care services purchased on behalf of users*." (Minister of Health, 2019, par 2.1.2)

142. While the first paragraph is general in nature and could apply to any country, the second specifies the principal problem as one of "*fragmentation of health care fund pools*". The policy solution to this problem has four elements to it.

142.1. First, it is proposed that an integrated pool be developed.

142.2. Second, it is proposed that a "purchaser-provider split" be developed.

142.3. Third, it is argued that the purchaser-provider split be delivered exclusively by one organisation, the NHIF.

142.4. Fourth, it is argued that both the above are, by implication, required to achieve universal health coverage (UHC).

143. Based on the above there however appear to be *three policy solutions without any connection to a stated problem*. While the "integrated pool" proposal derives from the fragmented pools

problem, the purchaser-provider split, the idea of a monopoly purchaser and the achievement of UHC lack any form of problem statement.

144. A review of past official documents offers no further clarity on the rationale for the purchaser-provider split approach, the proposal for a centralised purchaser that embodies the purchaser-provider split or evidence of the gaps in UHC. The various reasons put forward focus on the pooling issue (often with reference to equity considerations) and the adequacy of funds for the public sector. The equity considerations have also largely been framed in racial terms (Staff writer, 2019).

145. The 2011 Green Paper on NHI (National Department of Health, 2011c) specified the following problems in its "problem statement":

    145.1. "*Post 1994 attempts to transform the healthcare system and introduce healthcare financing reforms were thwarted. This has entrenched a two-tier system, public and private, based on socioeconomic status and it continues to perpetuate inequalities in the current health system. Attempts to reform the health system have not gone far enough to extend coverage to bring about equity in healthcare*." (National Department of Health, 2011c, par 9)

    145.2. "*The national health system has a myriad of challenges, among these being the worsening quadruple burden of disease and shortage of key human resources. The public sector has underperforming institutions that have been attributed to poor management, underfunding, and deteriorating infrastructure*." (National Department of Health, 2011c, par 13)

    145.3. "*In many areas access has increased in the public sector, but the quality of healthcare services has deteriorated or remained poor. The public health sector will have to be significantly changed so as to shed the image of poor quality services that have been scientifically shown to be a major barrier to access…* ." (National Department of Health, 2011c, par 14)

    145.4. "*Similarly to the public health system, the private sector also has its own problems albeit these are of a different nature and mainly relate to the costs of services. This relates to high service tariffs, provider-induced utilization of services and the continued over-servicing of patients on a fee-for-service basis. Evidently, the private health sector will not be sustainable over the medium to long term*." (National Department of Health, 2011c, par 15)

145.5. “To change these types of systems will require transformation of the healthcare financing model, better regulation of healthcare pricing, improvement in quality of healthcare as well as the strengthening of the planning, information management, service provision and the overhauling of management systems.” (National Department of Health, 2011c, par 16)

146. The above was followed roughly four years later with a revised problem statement contained in a White Paper (National Department of Health, 2015, Chapter 3). Here it listed what was referred to as structural problems in the health sector.

146.1. “Cost drivers in the public health sector;

146.2. “Costly private health sector;

146.3. “Poor quality of health services;

146.4. “Curative hospi-centric focus of the health system;

146.5. “Mal-distribution and inadequate human resources;

146.6. “Fragmentation in funding pools;

146.7. “Out-of-pocket payments; and

146.8. “Financing systems that punish the poor.”

147. The above was followed two years later with a further White Paper (National Department of Health, 2017) which revised the problem statement to highlight the following:

147.1. Social determinants of health (National Department of Health, 2017, p. 10);

147.2. Burden of disease (National Department of Health, 2017, p. 10);

147.3. Leadership and governance (National Department of Health, 2017, p. 12);

147.4. Service delivery challenges (National Department of Health, 2017, p. 12);

147.5. Quality of healthcare services (National Department of Health, 2017, p. 12);

147.6. Health workforce challenges (National Department of Health, 2017, p. 13);

147.7. Availability of medical products and technologies (National Department of Health, 2017, p. 13);

147.8. Costly private health sector (National Department of Health, 2017, p. 14);

147.9. Inequitable health care financing (National Department of Health, 2017, p. 15);

147.10. Fragmentation in funding pools (National Department of Health, 2017, p. 16);

147.11. Out-of-pocket payments (National Department of Health, 2017, p. 16); and

147.12. Weak purchasing and financing systems that punish the poor (National Department of Health, 2017, p. 17).

148. Of the above, only the last "problem" in any way relates to purchasing. The more detailed explanation is as follows.

148.1. "*Analysis of the available South African National Health Accounts data shows that there are three methods of financing health care namely through general tax, medical schemes (private health insurance) contributions and OOPs. South Africa has a relatively low share of mandatory prepayment funding in the context of the goal of UHC. The system has small, fragmented funding and risk pools, which limit the potential for income and risk cross-subsidisation. Health care services are not distributed in line with the need for health care services and the benefit incidence of health care in South Africa is very 'pro-rich', with the richest 20% of the population receiving 36% of total benefits (despite having a 'health need share' of less than 10%) while the poorest 20% receive only 12.5% of the benefits (despite having a 'health need share' of more than 25%)*." (National Department of Health, 2017, par 81)

148.2. "*South Africa also has weak purchasing mechanisms. At present, there is a relatively passive relationship between purchasers (i.e. those who hold a pool of funds and transfer these funds to providers) and service providers. Existing ways of paying providers in both the public and the private health sectors are inefficient. The current system of line-item budgeting in the public sector does not provide incentives for efficiency or for providing good quality care. Fee-for-service payments, as used within the private sector environment, creates an incentive to provide as many services as possible, even where these may not be medically necessary or appropriate, again generating inefficiencies*." [Reference citations excluded] (National Department of Health, 2017, par 82)

149. The above two paragraphs reflect the only motivation for a single purchaser that embodies the structural feature of a purchaser-provider split. No evidence or research is cited. No analytical report produced by the Department of Health or any other official structure is referenced to motivate either the diagnostic aspects of the statement or the resulting policy proposals. The

two paragraphs furthermore conflate questions of pooling (equity considerations) with purchasing issues. It is important to note that these two features of a health system are quite distinct. Pooling-related objectives are distinct from *purchasing-related* objectives.

150. Specific regard to questions of purchasing uncontaminated by pooling considerations make general reference to passive fee-for-service purchasing in the private health system and line item budgeting in the public system. No systematic analysis is offered of either.

151. It is worth noting that the recently published Health Market Inquiry (HMI) report (Competition Commission, 2019) included a substantial diagnostic of the private health systems methods of purchasing and pooling problems and made detailed structural recommendations.

152. Importantly, the HMI did not reach the conclusion that the policy response to purchasing concerns in the private health system required a consolidation of purchasing, i.e. the establishment of a *monopoly purchaser*. In fact, it reached the opposite conclusion, that more purchasers were required, and that barriers to entry for additional purchasers need to be reduced.

    152.1. "*Based upon our findings, we recommend a set of interrelated interventions designed to promote systemic change to improve the context within which facilities, funders, and practitioners operate, and create a shift towards a pro-competitive environment. These recommendations must be seen as a package. Market failures may persist if a partial approach to the implementation of our recommendations is adopted*." (Competition Commission, 2019, par 47)

153. The HMI therefore examined the same issues raised as problems in the NHI Green paper and the two NHI White Papers, and made substantial, but different, recommendations. Importantly, this is the only official examination of these issues post 2007. To address the concern of fragmented pools in the private sector it recommends the introduction of a *risk adjustment scheme*.

154. Importantly, the HMI recognised that equity concerns resulting from fragmented risk pools can be resolved without consolidating purchasing systems into monopolies. It therefore recommends that pooling be addressed through a centralised scheme, through a combination

of risk adjustment[23] and social reinsurance[24], while purchasing remain decentralised and competing. In this way the purchasers would need to compete on efficiencies and not equitable coverage.

154.1. "*We recommend the introduction of a risk adjustment mechanism linked to the single, comprehensive, standardised base benefit option to remove any incentive by schemes to compete on risk. Schemes should compete on metrics designed to attract new members, irrespective of their age, health, or risk profile. Regionally-based medical schemes should be allowed through a temporary reinsurance facility to mitigate their exposure to demographic and claims risk*." (Competition Commission, 2019, par 59)

155. It is worth noting that numerous official reports published after 1994 have come to the same conclusions as the HMI. They include:

155.1. The 1995 NHI Committee of Inquiry into National Health Insurance (Department of Health, 1995);

155.2. The Taylor Committee of Inquiry into Comprehensive Social Security of 2002 (Taylor Committee, 2002);

155.3. The NDOH's consultation document of 2002 based on the Taylor Committee of Inquiry (National Department of Health, 2002); and the

155.4. Ministerial Task Team on Social Health Insurance in 2005 (Ministerial Task Team on Social Health Insurance, 2005).

156. All of these reports recommend that pooling be separated from purchasing, and that purchasing functions be decentralised to either devolved organs of state or regulated private markets.

157. It is worth noting that the only (publicly available) official report to financially evaluate an NHI scenario stated as follows in 2005 (Ministerial Task Team on Social Health Insurance, 2005, p. 50):

[23] A system of inter-scheme transfers from those in less need, to those in more need.

[24] A system of transfers from schemes with high claims for their size, form those with larger risk pools.

“The National Health Insurance (NHI) option, even with a minimum benefit costed at the lowest level feasible, appears not to be affordable in the medium-term. Overall health expenditure would rise to exceed 11.3% of GDP. Were minimum benefits to be more comprehensive, the increases in overall health expenditure would be significantly in excess of this figure.

“Ignoring issues relating to supply and the organization of the health system and focusing only on the financial value of the subsidy, NHI will become affordable only if the level of formal employment rises coupled with significant increases in the average incomes of the formally employed population. This will only happen in the very long-term, and will depend fundamentally on the nature and extent of economic development.”

COUNTRIES CITED AS PART OF THE RATIONALE

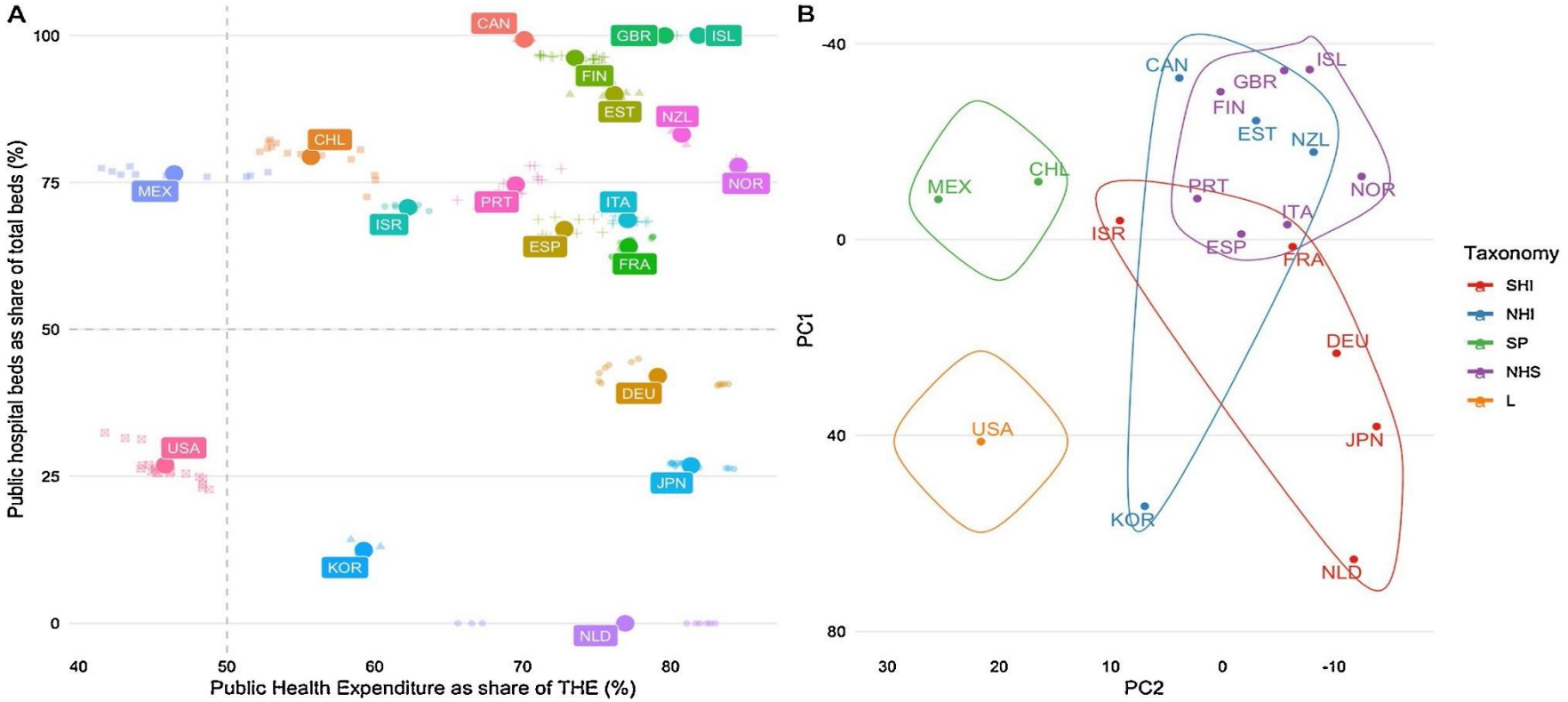
158. Various countries are often (loosely) cited as examples of NHI initiatives. More recently, the terminology has changed to refer only to UHC initiatives. See for instance the NHI information pamphlet provided on the NDOH website (National Department of Health, 2019, p. 7):

> "*Many countries have started implementing Universal Health Coverage even before the United Nations adopted it as one of the Sustainable Development Goals of the world. Countries call it by different names but the goal is one, namely Universal Health Coverage whereby every citizen in every country has financial coverage for their health care needs instead of only a selected few as it is happening in our country.*
>
> *"The United Kingdom (UK) started it in 1948 and called it NHS. Japan started in 1961. Mexico started in 2001 and call it Seguro Populare. Brazil has it, all the Scandinavian countries have very good Universal Health Coverage Systems.*
>
> *"On the African Continent, Ghana has started. Rwanda has also started*."

159. While all the countries mentioned have UHC strategies underway, none are seeking to implement reforms equivalent to the NHI proposals in South Africa. Attempts to clarify the political use of terminology has caused various writers to address health system typologies more rigorously (also see **figure 11** for an illustration of the variation in typologies).

> *"… while there is a wide consensus among the authors defining the NHI-model as a single fund and single-payer system with universal coverage, several countries name their health insurance schemes, a national public institution or a specific national health program "National Health Insurance", regardless the health financing system of the country … For example, Israel names "National Health Insurance" their country SHI-model based on a multi-insurance system. Japan uses "National Health Insurance" to refer to one of the two major types of health insurance schemes in the country, which targets the population not eligible for insurance provided by the employee, in the context of a SHI-model. Several African countries such as Ghana, Kenya or Tanzania have insurance schemes denominated "National Health Insurance". Nevertheless, these schemes are not universal, as they cover only a small percentage of the population (11 - 35%) - mainly formal sector employees … These uses of the term NHI have probably contributed to some confusion in the literature*." (Cuadrado, Crispi, Libuy, Marchildon, & Cid, 2019, pp. 624-625)

Figure 11: Classification of country health systems



CAN=Canada; FIN=Finland; GBR=Great Britain; ISL=Iceland; EST=Estonia; NZL=New Zealand; MEX=Mexico; CHL=Chile; ISR=Israel; PRT=Portugal; ITA=Italy; NOR=Norway; ESP=Spain; FRA=France; USA= United States of America; DEU= Germany; JPN= Japan; KOR= Korea; NLD= Netherlands; THE=Total Health Expenditure; PC= Principal Component; SHI=Social Health Insurance; NHI=National Health Insurance; SP=Structured Pluralism; NHS=National Health Service; L=Liberal.

(Cuadrado et al., 2019, p. 626)

160. Of the various countries cited in the South African NHI process none are comparable to South Africa, and none have NHI frameworks, even where they may refer to parts of their system as an “NHI”.

160.1. *Japan*: there are eight insurance systems in Japan, with around 3,500 health insurers. There are two systems. First there is Employee’s Health Insurance (provided through multiple insurers – union managed health insurance, government managed health insurance, seaman’s insurance, National Public Workers Mutual Aid Association Insurance, and private school teachers’ and employees’ mutual aid association insurance); and second, there is what is referred to as NHI (for the self-employed and students, and social insurance for corporate employees). (Sakamoto et al., 2018)

160.2. *Mexico*: there are *four* sub-systems that make up the UHC framework. These are: public care provided through the states, with partial subsidisation by the federal government; a social health insurance regime for employed families; a scheme for public employees; and the Seguro Popular (popular health insurance) for people who cannot access either of the other two contributory schemes. The Seguro Popular was introduced to target an uncovered group and is partially subsidised by the federal government. (Knaul et al., 2012)

160.3. *Thailand*: the UHC framework in Thailand is achieved through three programmes and voluntary private insurance: the system for civil servants and their families (general tax funded); social security for private employees (tripartite payroll taxes); private voluntary insurance (risk-related contributions); and a residual, basic coverage, insurance scheme targeted at the families not covered by either of the other two schemes (general tax funded). (Jongudomsuk et al., 2015)

160.4. *Brazil*: there are two basic systems operating in Brazil. The first is a free public service that is funded from general and payroll taxes. The second is private insurance for those with adequate incomes. The public system is highly decentralised through a regionalised (to sub-national levels of government) and decentralised network of healthcare service providers. The decentralisation strategy has resulted in the expansion of important programmes, such as the Family Health

Programme, to large parts of the population (although UHC is still not achieved) (Elias & Cohn, 2003).

160.5. *Chile*: has two main sub-systems. First, there is private health insurance offered through competing private health insurance. Employees are mandated to contribute 7% of their salary for coverage. Contributions can be supplemented on a voluntary basis. All revenue is derived from contributions. Second, for those who cannot afford private insurance, there is a public system. This system is financed through a combination of social security contributions and general taxes. As the private insurance system was permitted to discriminate against members on the basis of their health status, sicker people tend to drop into the state system. In 2010, however, discrimination based on health status was outlawed by the Constitutional Court.

161. In reviewing country typologies, no reform similar to that proposed in the NHIB could be found. When pursuing UHC strategies, countries tend to prioritise serious coverage gaps, with discrete schemes established for that purpose. Where countries have substantial free public systems, strategies tend to focus on incremental budget improvements and decentralisation. No country could be found that attempts to improve their general tax funded public systems by collapsing private coverage coupled with a dramatic increase in general taxes.

162. *Countries such as Thailand, Japan, Brazil, Mexico and Chile continuously attempt to improve the fairness of their UHC approaches through targeted reforms that nevertheless retain the integrity of their pre-existing sub-systems*.

Public statements

164. In a key statement made to BusinessTech the representative of the NHI process for over ten years, Olive Shisana, outlined what she regarded as the principal case for the centralised purchasing arrangement :

> "For NHI to be affordable, efficient and equitable, it needs a national resource pool that will be used to provide health services to all, said Shisana.
>
> ""This is an instrument to end the race, class, gender divisions that continue to plague South Africa. For example, 76% of medical scheme members are white, and only 10% are black africans.[sic]"
>
> "She said that if medical schemes are allowed to offer the same services as NHI, most of the specialists, doctors, dentists, and allied health professionals will simply provide care to the mostly white people and leave black African people with under-resourced providers.
>
> ""This maldistribution of human resources is at the root of the health care crisis," Shisana said." [Underline added]

165. Given that Shisana occupied the position of chairperson of the NHI Ministerial Advisory Committee for roughly 10 years from 2009 (National Department of Health, 2009) and is presently the advisor on health policy and NHI within the Presidency (current), her views plainly carry official status. While her comments are not expressly contained in any official report, they could reasonably be interpreted as lying behind the policy framework.

166. Three issues stand out from this set of statements.

    166.1. First, it is principally a comment concerning pooling, i.e. it deals with the fair allocation of resources. No mention is however made of the rationale for purchasing efficiencies.

    166.2. Second, it racialises the motivation, arguing that the resource allocation problem (pooling problem) results in a bias for white people and disadvantages "black African" people. No mention is made of other population groups.

    166.3. Third, it argues that the pooling problem is principally about the "maldistribution" of health professionals. This she argues "*is at the root of the health care crisis*".

167. Simply put, Shisana lays the concern of the entire healthcare "crisis" at the door of the distribution of health professionals, which is perversely influenced by white dominated medical schemes.

168. The General Household Survey (Statistics South Africa, 2019, p. 119) however reports that the largest population group on medical schemes is Black African at 48.6%, with Whites only making up 34.4% of the total.

- Black African: 48.6% (4.6 million)
- Coloured: 9.1% (0.8 million)
- Indian/Asian: 7.8% (0.7 million)
- White: 34.4% (3.2 million)

169. It appears that what Shisana was referring to was the percentage of each population group on medical schemes. This is more consistent with the numbers she used, but adds little obvious value to a rationale for reform, other than an apparent attempt to construct a "race-based" rationale for the reform.

- Black African: 9.9%
- Coloured: 17.1%
- Indian/Asian: 52.0%
- White: 72.9%

170. If we take Shisana's argument seriously, it however makes little sense as the population-based numbers are strongly affected by the size of the underlying population groups, which have no systemic implications for any aspect of the health system. The inconsistency of the implied linkage to the NHI proposals is best illustrated with reference to the Indian/Asian population group. Whereas 52.0% of the Indian/Asian population group is on medical schemes, this constitutes a population size of only 0.7 million. This in comparison to the 4.6 million Black/African population on medical schemes. It is self-evident that no coherent conclusion regarding the structure and nature of the health system can be drawn from this observation.

171. From a socioeconomic perspective, however, the obvious fact that can be drawn from these numbers is that the Black/African population group now dominates the so-called middle class (and higher) in South Africa.

172. Apart from the race-based rationale, Shisana argues that the NHI reform framework is premised on the maldistribution of the health professionals. This kind of argument is closer to a genuine discussion on health reform.

173. However, for this argument to have substance, evidence is needed to demonstrate that the distribution of health professionals is related to the existence of a private health system, rather than alternative factors, such as conventional fiscal constraints, service prioritisation (i.e. the de-prioritisation of specialist and sub-specialist hospital services) and poor management (which drives staff away and/or results in moonlighting).

174. With respect to the distribution of health professionals it is noteworthy that despite Shisana placing weight on this argument as the central motivation for the NHI proposals, no official report can be found which performs any analysis on health human resources and which makes any findings consistent with her views. This is despite having 10 years as chairperson of the Ministerial Advisory Committee on NHI to produce one.

175. The most recent report dealing with health-related human resources in South Africa produced by the NDOH is for 2011 (National Department of Health, 2011b). However, there are no findings consistent with her remarks to be found in the document.

176. The medical practitioner distribution reflected in the report suggests a nearly even ratio per 10,000 population between the private and public sector populations (National Department of Health, 2011b, p. 29):

    176.1. Public sector: 3.7 (per 10,000)

    176.2. Private sector: 3.8 (per 10,000)

    176.3. South Africa: 3.7 (per 10,000)

177. According to the NDOH around 72% of health professionals are in the public sector (**table 8**). These numbers do not even take into account the substantial increases in health professionals employed in the public sector to 2016 which are reflected in **table 9**. For instance, relative to the 2011 estimate, the number of medical practitioners has now increased from 11,875 to 14,454.

Table 8: The distribution of health resources between the public and private systems as reflected by the National Department of Health human resource strategy in 2011

	Public	Private	Total	Public	Private
Medical practitioners	11 875	7 359	19 234	61.7%	38.3%
Medical specialists	4 444	6 658	11 102	40.0%	60.0%
Nurses	120 157	42 489	162 646	73.9%	26.1%
Allied	34 010	28 745	62 755	54.2%	45.8%
Clinical support	67 861	7 581	75 442	90.0%	10.0%
Total	**238 347**	**92 832**	**331 178**	**72.0%**	**28.0%**

Source: (National Department of Health, 2011a)

178. The total number of nurses in the public sector has also increased, from 120,157 in 2011 to 136,552 by 2016. However, it is worth noting the important qualification on private sector nurse numbers stated by the NDOH itself, which clarifies that many nurses working in the private sector serve the non-medical scheme (uninsured) population.

> "*Note that the number of private sector nurses includes both nurses who are formally employed in the private hospital sector (about a third of the total) and elsewhere. The bulk of private sector nurses work for NGOs, mining hospitals, pharmacy clinics, etc. It is important to note that most of these organisations serve mainly the uninsured population, which means that the population ratios for public and private sector would not be entirely correct*." (National Department of Health, 2011b, p. 30)

179. With respect to medical specialists, **table 9** indicates a substantial increase in public sector employment levels to 4,990 by 2016. While the distribution between the public and private systems is not equivalent to that for medical practitioners, this is due largely to the emphasis placed by the public health system on primary care rather than sub-specialist services from 2002 to 2015/16. For instance, the real change in expenditure on district health services has been around 4% per annum compared to central hospital services at 1.2% per annum over this period (Blecher et al., 2017).

180. *Based on official information sources it is unclear how the argument for a central purchaser, other than the current public sector, can be motivated rationally from the human resource information at hand*. It is furthermore unclear how such a central rationale for the NHI framework can be motivated without any underlying technical report that shows the relationship between the diagnosed problem and the policy solution.

Table 9: Human resource changes in the public health system, from 2006 to 2016

Occupational classification	As at March of the given year					10 year change (%)	% of total (2016)	
	2006	2008	2012	2016	Change			
Professional Nurses	**44 245**	47 975	58 274	**66 024**	**21 779**	49.2%	33.6%	
Nursing Assistants	**31 923**	34 082	35 377	**32 843**	**920**	2.9%	16.7%	
Staff Nurses and Pupil Nurses	**20 866**	22 781	29 353	**30 774**	**9 908**	47.5%	15.7%	79.7%
Medical Practitioners	**9 603**	10 781	13 204	**14 454**	**4 851**	50.5%	7.4%	
Ambulance and Related Workers	**7 672**	10 304	11 308	**12 361**	**4 689**	61.1%	6.3%	
Student Nurses	**8 944**	9 789	10 816	**6 911**	**-2 033**	-22.7%	3.5%	
Medical Specialists	**3 711**	4 050	5 198	**4 990**	**1 279**	34.5%	2.5%	
Radiography	**2 109**	2 155	4 714	**4 973**	**2 864**	135.8%	2.5%	
Health Sciences Related	**2 388**	4 423	4 247	**3 751**	**1 363**	57.1%	1.9%	
Optometrists and Opticians	**52**	33	2 310	**2 445**	**2 393**	4601.9%	1.2%	
Emergency Services Related	**168**	611	2 240	**2 360**	**2 192**	1304.8%	1.2%	
Pharmacists 1 755	**2 157**	3 710	4 874	**1 955**	**-202**	-9.4%	1.0%	
Medical Research and Related Prof.	**80**	69	2 076	**1 731**	**1 651**	2063.8%	0.9%	
Pharmaceutical Assistants	**409**	648	1 439	**1 723**	**1 314**	321.3%	0.9%	
Physiotherapy	**790**	908	1 069	**1 306**	**516**	65.3%	0.7%	20.3%
Dieticians and Nutritionists	**515**	612	940	**1 253**	**738**	143.3%	0.6%	
Occupational Therapy	**672**	789	1 020	**1 251**	**579**	86.2%	0.6%	
Dental Practitioners	**719**	655	997	**1 143**	**424**	59.0%	0.6%	
Supplementary Diagnostic Radiographers	**186**	180	904	**982**	**796**	428.0%	0.5%	
Psychologists and Vocational Counsellors	**406**	441	669	**774**	**368**	90.6%	0.4%	
Speech Therapy and Audiology	**283**	337	491	**702**	**419**	148.1%	0.4%	
Medical Technicians/Technologists	**819**	413	464	**515**	**-304**	-37.1%	0.3%	
Environmental Health	**883**	820	902	**442**	**-441**	-49.9%	0.2%	
Oral Hygiene	**143**	159	308	**336**	**193**	135.0%	0.2%	
Dental Specialists	**41**	32	143	**173**	**132**	322.0%	0.1%	

Occupational classification	As at March of the given year					10 year change (%)	% of total (2016)	
	2006	2008	2012	2016	Change			
Dental Therapy 147	**146**	259	318	**112**	**-34**	-23.3%	0.1%	
Community Development Workers	**202**	164	96	**95**	**-107**	-53.0%	0.0%	
Dental Technicians	**38**	39	42	**45**	**7**	18.4%	0.0%	
Total	**140 170**	**157 219**	**193 793**	**196 424**	**56 254**	**40.1%**	**100.0%**	**100.0%**

Source: Data from the Vulindlela system based in National Treasury as reported in (Blecher et al., 2017, p. 30)

Conclusion on rationales

181. For a policy proposal to be regarded as rational within the context of an open democratic society, particularly where the policy is far-reaching and poses significant potential risks for society, it is both a matter of common sense as well as a legal obligation that Government presents its case with a defensible technical rationale.

182. To date no coherent rationale has been laid out that expressly relates to the core elements of the proposed NHI framework. **Table 10** provides a grouped summary of the key health system problems provided, their relationship to the key strategic policy proposals and an indication of the extent to which evidence has been provided on the relationship between the problem and the policy recommendation.

183. The strategic policy elements are divided into *pooling* (that is centralised pooling), the proposal for the entire health system to be structured into a *purchaser-provider split*, and the proposal for a *monopoly purchaser*. The problems identified in the various official documents are broadly categorised into 14 problem themes. While most themes recur, at least four occur only in the second White Paper.

184. The following is exhibited in **table 10**:

    184.1. Six of the themes have a relationship to recommendations relating to pooling. Of these, not one is based on any evidence of a linkage between the problem and the proposed reform.

    184.2. Two themes bear some possible relationship to the idea of a purchaser-provider split. However, no evidence has been produced to clarify the exact nature of the problem and the relationship to the selected policy recommendations.

    184.3. Four themes have some possible relationship with the recommendation for a monopoly purchaser. These largely relate to areas where possible efficiencies (public and private sector) could result from the market power of a large national monopoly. However, no evidence is provided as to how this will occur and not result in even greater inefficiencies – which is a common feature of monopolies in general and state monopolies in particular.

    184.4. Five of the problem statements bear no relationship to the policy recommendations. For these, no evidence has been produced to clarify their relationship to the

proposed policy framework. These problem themes appear to have been included merely to state general problems in the health system.

185. Overall, therefore, the NHI policy framework lacks any documentation that clarifies the technical rationale for the policy proposals. The official documentation demonstrates a clear misalignment between problem statements and subsequent policy proposals.

186. Given the time lapse between the initiation of the Ministerial Advisory Committee in 2009, under the chairpersonship of Olive Shisana, and the publication of the Bill in 2019 and the expenditure of several billion rand, the absence of any technical substance to the proposals is a matter of concern. *This is especially a concern as the proposals involve drastic changes to the health system that largely eliminate the role of provincial governments and medical schemes in health coverage*.

Table 10: List of problems identified and their relationship to a possible rationale for the proposed reforms

	Problem specified	Source	Relationship to reform proposal			Evidence provided in the form of research and analysis
			Pooling	Purchaser-provider split	Monopoly purchaser	
1	**Two-tier system generates inequity, inequitable health financing arrangements, financing systems that punish the poor**	Green Paper White Paper 1 White Paper 2	Yes	None	None	None
2	**Fragmentation in funding pools**	White Paper 1 White Paper 2 NHI Bill	Yes	None	None	All official reports and inquiries distinguish pooling recommendations from purchasing recommendations. But there are no analyses produced for the NHI proposals
3	**Quadruple burden of disease, social determinants of health**	Green Paper White Paper 2	None	None	None	None
4	**Under-performing institutions in the public sector attributed to poor management, underfunding and deteriorating infrastructure**	Green Paper	None	None	None	None
5	**Quality of care poor in the public sector which is a barrier to access**	Green Paper White Paper 1 White Paper 2	None	Unclear, but possible	Unclear, but possible	None

	Problem specified	Source	Relationship to reform proposal			Evidence provided in the form of research and analysis
			Pooling	Purchaser-provider split	Monopoly purchaser	
6	**Curative hospi-centric focus of the health system**	Green Paper White Paper 1	None	None	None	None
7	**Private health sector costs**	Green Paper White Paper 1 White Paper 2	Yes	Already exists in the private sector	Yes	HMI provided evidence and recommendations that contradict the idea of a monopoly purchaser
8	**Cost drivers in the public health sector**	White Paper 1	None	None	Yes	None
9	**Mal-distribution and inadequate human resources, Health workforce challenges, health professionals concentrated in the private sector**	White Paper 1 White Paper 2 Shisana	Yes	None	None	The NDOH report of 2011 contradicts the NHI problem statements Apart from this, no evidence has been produced to support the policy recommendations
10	**Out-of-pocket payments**	Mentioned in the Green Paper, but not in its problem statement White Paper 1	Yes	None	None	None

	Problem specified	Source	Relationship to reform proposal			Evidence provided in the form of research and analysis
			Pooling	Purchaser-provider split	Monopoly purchaser	
		White Paper 2				
11	**Leadership and governance**	White Paper 2	None	None	None	None
12	**Service delivery challenges**	White Paper 2	None	None	None	None
13	**Availability of medical products and technologies**	White Paper 2	Yes	None	None	None
14	**Weak purchasing and financing systems that punish the poor**	White Paper 2	None	Yes	Yes	None

CRITICAL REVIEW OF THE NATIONAL HEALTH INSURANCE BILL PROVISIONS

187. While there are many detailed aspects of the NHIB that raise serious concerns, this review outlines those that aspects that are strategic in nature and talk to the validity of the overall reform framework.

188. The concerns are broadly divided into two aspects.

    188.1. First, the feasibility, appropriateness and risks associated with the institutional framework; and

    188.2. Second, the feasibility and appropriateness of the financial framework.

189. Before going into the more detailed aspects of the above two areas, a number of concerns apply to the overall reform framework and proposals. These are as follows:

    189.1. *The rationale for the NHI framework has not been properly stated*. At no point has a clear connection been made between the well-established weaknesses of the health system and the recommended policy framework. In fact, the evidence points to quite different sets of reforms – both within the public and private sectors.

    189.2. *The proposed reforms have not been the subject of feasibility studies that should normally accompany a set of proposals that propose to substantially disrupt pre-existing public and private sector health coverage regimes*. It is deeply concerning the following studies have not been performed or made public:

        189.2.1. A technical review that clearly establishes the coverage failures in the current UHC framework in South Africa. As South Africa technically complies with the UHC, it is important to understand which UHC gap requires such a dramatic departure from existing forms of coverage. It is worth noting that the International Labour Organisation World Social Protection Report of 2017 found no coverage gaps in South Africa (International Labour Office, 2017, p. 368).

            - Legal health coverage deficit, % of population without legal coverage = 0%
            - Percentage of the population not covered due to financial resource deficit = 0%

- Percentage of population not covered due to health professional staff deficit = 0%

189.2.2. An institutional feasibility study, which collates the evidence from international best practice and local empirical research to demonstrate how the public interest will be served. This should also demonstrate that the proposals represent the least disruptive route to the achievement of improved UHC. This study should, in particular, validate the claims made that a state-run monopoly purchaser operated by political appointments will produce efficiencies that are able to justify the intervention.

189.2.3. The prescribed feasibility studies required for any consideration of government components as required by the Public Service Act of 2007. It is disconcerting that proposals have been made for poorly governed national entities without the required statutory evaluations. This is particularly needed as the NHI pilot appraisals indicated that nothing was learned concerning any proposed contracting units or health district structures (Genesis, 2019).

189.2.4. A study that carefully considers the international evidence relating to the decentralisation of health functions, the systems of financial transfer required to preserve equity and the accountability regimes that ensure that services are planned, financed and managed in a manner that is responsive to the served population. It is deeply troubling that given South Africa's decent into institutionalised forms of corruption due to entrenched systems of patronage that no identifiable research of any form was performed in 10 years in this key problem area.

189.2.5. A financial feasibility study, which is capable of demonstrating: first, whether it is fiscally feasible to raise taxes to the levels required for a monopoly purchaser to guarantee social protection for the entire population without diminishing any person's current legitimate rights to health cover. Importantly, to the extent that any person's access to health is threatened or undermined without a rational public purpose, this can be deemed reckless and irrational.

189.2.6. A valid[25] legal assessment of the constitutionality of the following proposals: first, the re-direction of the PES to national government; second, the emasculation of the powers allocated to provinces in terms of schedules 4(A) and 4(B) of the Constitution through national statute and the redirection of funds through national structures; and third, the prohibition of parallel coverage through medical schemes and even out-of-pocket purchases without any specified or determinable public purpose (noting that such prohibitions do not exist anywhere else in the world).

189.3. Finally, it is concerning that a substantial onus is placed on the general public to engage on policy proposals that have not passed though even the most rudimentary of policy appraisals. These are high-risk proposals that should have been properly vetted before being submitted to Parliament.

Institutional framework

190. The proposed institutional framework raises a number of fundamental concerns that question the appropriateness and feasibility of aspects of the proposed institutional model.

191. As already noted, a major feature of these concerns is the absence of any rational assessment of the institutional options and rationale for the proposed choices made. Overall, the framework appears not to have been fully thought through, which would explain the general absence of any supporting research or evidence.

192. The following are the central concerns with the proposed framework aside from those already raised as part of earlier analyses concerning the rationale:

192.1. The framework substantially undermines the Constitutional powers of provinces to finance, plan and run health services. The constitutionality of this aspect of the framework is clearly in question.

192.2. The centralisation of the PES is effectively an intrusion by national government into the legitimate tax revenue of provinces to carry out their constitutionally mandated functions, which includes health services and ambulance services. The reference of

[25] The evaluation presented to Parliament by the state legal advisors fails to adequately address any of the Constitutional questions that arise both in terms of the proposed legislation and consequential to it.

schedule 4(a) to “health services” plainly requires that all aspects of the health services are legitimately the domain of provincial governments, including financing (raising and allocating funds), planning and service delivery. These powers include all personal health services (hospitals, clinics and transport services). A simple piece of plenary legislation cannot take precedence over the Constitution. Furthermore, the Constitution cannot be circumvented by stealth – which is plainly the purpose of the NHIB and related amendments to the National Health Act.

192.3. The centralisation of purchasing, either via the NHIF or the DHMOs cannot reasonably be argued to improve efficiencies and local responsiveness. Communities have no say over any aspect of the proposed national framework, and the complaints regime is not independent (i.e. it is dominated by political appointments).

192.4. Successful models internationally involve local autonomous structures that are accountable for performance to communities through local governance structures (Bossert & Mitchell, 2011; Bossert, Mitchell, & Janjua, 2015; Rubio, 2011; Santín Del Río, 2004; Sumah et al., 2016; Yilmaz, Beris, & Serrano-Berthet, 2010). Moves that shift health systems toward decentralisation are technically sound, and also reflect the shift away from authoritarian forms of concentrated power (see for instance Smulovitz & Clemente, 2004).

192.5. There is furthermore no evidence to suggest that the performance failures in the public health system have resulted from the absence of a purchaser-provider split operated by a monopoly purchaser. There is substantial evidence that the failures are attributable to governance weaknesses and the institutionalised systems of patronage that operate in eight out of nine provinces. *This is motivated in the analysis presented above regarding the performance of the public health system*.

192.6. While performance has been poor in eight of the nine provinces, the reason for the performance failures relate to correctable features of the governance framework – which include failures of national government. These are attributable to the patronage that has operated through political office-bearers.

192.6.1. The most appropriate and logical step-wise reform path would be to establish de-politicised health authorities at a provincial level to finance, plan and deliver healthcare.

192.6.2. Instead, the NHI framework proposes to maintain the system of political appointments, but now to have these appointments placed within an organisational context where power is highly concentrated nationally in the hands of political office-bearers.

192.6.3. This essentially combines patronage with concentrated power. Such institutional models are universally predatory and cannot be justified on public interest grounds.

192.7. The degree of concentrated power in the hands of political appointees is unprecedented in South Africa, and represents both a threat to the viability of the health system, together with an existential threat to democracy.

192.7.1. It is plainly the intention of the political actors behind these proposals to concentrate upward of 8% of gross domestic product (GDP) in their hands. This may in fact be the primary impetus behind these proposals.

192.7.2. While it is fiscally not possible for the intended financial concentration to emerge at the intended levels, the concentration of regulatory power is at least equivalent.

192.8. The attempt to replace medical schemes as purchasers of care for families with adequate incomes is also implausible and is fiscally unobtainable. It is quite probable that this is understood by Government, which is why they will not release into the public domain any financial feasibility assessment.

192.8.1. However, despite this, it appears as though the reform framework envisages disrupting the social protection framework offered through medical schemes prior to the establishment of a viable public scheme. This would be reckless and deserving of appropriate sanction in the courts.

192.8.2. It is worth noting that there is not a single technical review of the financial viability of the NHI framework that has suggested it is feasible. This includes Government's own submissions to cabinet (Ministerial Task Team on Social Health Insurance, 2005).

192.8.3. The health market inquiry (HMI) has, by way of contrast, offered a clear institutional approach to address weaknesses in the private sector, reflective of international best practice, which can be implemented without social risk or disruption to existing well-established health systems, and achieve a stable private contributory system as a key component of South Africa's UHC system.

192.8.4. Importantly, the HMI invested in significant research and consultation, unlike the NHI process. It would be irrational for government to favour a high-risk institutional reform that is not supported by evidence over a reform proposal, also carried out by official structures, which is backed up five-years of documented evidence gathering.

Financial feasibility

193. Over a period of 10 years the NHI process has been unable to generate a financial feasibility assessment of the NHI framework. After the publication of the 2017 White Paper on NHI the Davis Tax Commission (DTC) raised the following concerns which have to date not been addressed:

> "*The large degree of uncertainty and lack of common understanding of how the NHI will be implemented and operate is of concern, given the magnitude of the proposed reform*." (Davis Tax Commission, 2017, p. 42)
>
> "*Given the considerable size of projected funding shortfalls, substantial increases in VAT or PIT and/or the introduction of a new social security tax would be required to fund the NHI*." (Davis Tax Commission, 2017, p. 44)
>
> "*The magnitudes of the proposed NHI fiscal requirement are so large that they might require trade-offs with other laudable NDP programmes such as expansion of access to post school education or social security reform*." (Davis Tax Commission, 2017, p. 44)
>
> "*Given the current costing parameters outlined in the White Paper, the proposed NHI, in its current format, is unlikely to be sustainable unless there is sustained economic growth*." (Davis Tax Commission, 2017, p. 44)

194. A 2005 briefing of Cabinet echoed the above comments of the DTC. In this report various reform scenarios were modelled for viability. Four incremental reforms (representing scalable

adjustments on the existing health system (public and private) and one non-incremental reform (NHI). From the report the NHI option was included principally for completeness, not because it was being taken seriously by government at the time.

> "*The National Health Insurance (NHI) option, even with a minimum benefit costed at the lowest level feasible, appears not to be affordable in the medium-term. Overall health expenditure would rise to exceed 11.3% of GDP. Were minimum benefits to be more comprehensive, the increases in overall health expenditure would be significantly in excess of this figure*." (Ministerial Task Team on Social Health Insurance, 2005, p. 50)

195. There is no official or research-based analysis that has ever produced different results to the above, as the basic analysis is relatively straightforward. A basic minimum package that is no lower than existing basic packages can be costed and extrapolated to the national population. Given that the entire package must be funded from general taxes rather than household contributions to a scheme of their choice, the challenge of raising taxes arises.

196. A constraint particularly arises where general taxes are raised from existing tax bases, which are predominantly from medical scheme members (directly or indirectly), in order to return to them a lower benefit (there are no scenarios where the benefit can be better) in a system they have not chosen. It is for this reason the various ministers in charge of this process ultimately gave up the pretence that they were doing any serious financial feasibility assessments.

> "[The minister of health] … *added that the budget for the NHI has yet to be confirmed, and that initial estimates of R256 billion were a thumb-suck by a local accounting firm. "We made a mistake on the figures. I then went to the World Bank and the World Health Organisation and they asked why am I trying to do this, it can't be quantified by any human being because the costs are so variable*." (Staff reporter, 2018)

197. The above comment by the former Minister of Health is seriously inaccurate. A financial feasibility analysis tests the key risk parameters of a reform proposal as part of a standard reality check. It is not required to exactly match required institutional expenditures. Over a period of 10 years a considerable amount of financial assessments could have been performed to validate whether the institutional reform matches the financial implications. However, according to the Minister, no such basic work was ever performed. <u>Despite this, a reform trajectory that has no possibility of realisation is still pursued</u>.

198. Furthermore, the general increase in taxes is required to fund a covered group, medical scheme members. True UHC reforms focus on uncovered groups. But as South Africa has no uncovered groups, with those with adequate incomes largely funding their own care out of disposable incomes (not tax funds) in a regulated market, the justification for the tax increase and its associated forced nationalisation of cover, appear egregiously excessive and lacking in a rational public purpose.

199. The contrived rationale that health professionals are concentrated in the private sector cannot be defended on the available evidence, and cannot be used as a rationale when in 10 years no serious attempt has been made to produce a valid analysis of the problem.

200. All the technical work to date, including all official inquiries and task teams, has confirmed that that a substantial medical scheme system must co-exist with a substantial public system for the foreseeable future. Given this, it would be irresponsible, irrational and reckless of government to disrupt both the public and private systems to achieve what is obviously unachievable. The only responsible way forward is to restructure the governance framework of the public health system, and properly regulate the private health system as proposed by the HMI.

PART 4: SUMMARY OF FINDINGS

This part provides a summary of key findings from the entire report.

FINDINGS

General comment

201. The overwhelming conclusion that can be reached when reviewing the NHIB and associated proposals, is that:

    201.1. First, they have not been thought through;

    201.2. Second, they are lacking in evidence of their public purpose;

    201.3. Third, they are not based on a coherent rationale (which also forms part of the evidence requirement);

    201.4. Fourth, they have not been evaluated for feasibility despite nearly 11 years of apparent work;

    201.5. Fifth, they pose significant risks to the public and private health systems without any evidence of advantage to the general public;

    201.6. Sixth, they do not expressly address the actual problems that exist in the health system; and

    201.7. Seventh, they ignore viable and easier to implement reforms that are already identified, (see below) and that relate to actual problems in the health system.

202. It is my firm conclusion, therefore, that the NHI proposals, as presently advanced, are un-implementable, irrational and unconstitutional.

203. Furthermore, the failure to consider more reasonable and justifiable, evidence-based approaches to health reform that have in fact been outlined in numerous inquiries and official reports could attract the charge that Government is being reckless.

    (Armstrong et al., 2004; Competition Commission, 2019; Council for Medical Schemes, 2006, 2008; Development Bank of South Africa, 2008; Health Market Inquiry (South Africa), 2018; Minister's Advisory Committee on Health: Finance Technical Task Team, 2009; Ministerial Task Team on Social Health Insurance, 2005; National Department of Health, 1995, 1997b, 2002; Taylor Committee, 2002; van den Heever, Nthite, & Khumalo, 2006).

Feasibility

204. The NHIB envisages a final institutional framework that cannot be achieved in the foreseeable future, or even the long-term. It is over-ambitious in its conception and unjustifiably optimistic about the proposed social advantages.

205. Feasibility is in question with regard to both the envisaged intuitional framework and the fiscal implications of the final model.

    205.1. First, the institutional framework, which implies the complete replacement of the provincial and private sector functions of financing, planning, organising and purchasing health, is plainly too ambitious for the current capabilities of the health system.

    205.2. Second, the fiscal requirements for the substitution of medical schemes contributions with general tax increases is plainly unachievable. It is quite evident that the failure of the NDOH and National Treasury to produce a financial feasibility study results from this realisation.

    205.3. Third, the inclusion of a corporate governance model for the NHIF and related organisations, based on political appointments, condemns any version of the proposals to failure. This governance approach has driven institutionalised under-performance throughout the public sector and all state-owned enterprises, which will be no different in this instance.

206. The model presented in the NHIB prematurely includes provisions that remove social protections from other important pieces of legislation, thereby presupposing that the proposals will reach maturity within the medium-term. Whereas full implementation is next to impossible, any attempt to remove existing protections within the context of such uncertainty is irresponsible.

Rationale

207. Reforms always need to be justified on rational grounds. The need for clear reasons why a reform is needed is now well established through the requirement for policies and laws to be rational.

208. Taking this into account, there are three key features of the NHI proposals that, on review, require substantiation through the elaboration of a clear and reasoned evidence-based rationale:

    208.1. First, the extent of required pooling, together with the institutional mechanisms by which pooling will be achieved.

    208.2. Second, the need for the entire health system to be converted into a purchaser-provider split.

    208.3. Third, the need for a monopoly purchaser.

209. As things stand, despite over ten years of apparent constant work on the NHI framework, and up to R3.8 billion spent on NHI pilot projects, no evidence has been generated that clarifies what problem the NHI proposals are seeking to solve and why the proposed interventions are the most effective way forward.

210. While a clear case can be made for improvements to the various systems of pooling, no rationale or evidence has been produced to justify why South Africa should pursue centralised models of purchasing (by this is generally meant, planning, procuring and organising health provision), and a complete separation of purchasing and healthcare provision.

211. Most well run health systems around the world centralise pooling (i.e. the system of financial transfers required to ensure equitable access to healthcare) and decentralise planning, organising, purchasing and running health services. To do the opposite, which is what the NHIB proposed, requires a very carefully considered evidence-based motivation.

212. The HMI has provided an extensive evaluation of the systemic reforms required to address the market failures of the private health system – an apparent concern outlined in the NHI green and white papers. The HMI proposals however do not support that the market failures be addressed through the establishment of a monopoly purchaser. Instead, the HMI argues for targeted institutional reforms that would make the market work more efficiently and, importantly, serve the public interest.

213. Two considerations flow from the HMI report:

    213.1. First, the system of medical schemes can be made to work more efficiently without the need for government to take over the purchasing functions of the private health system.

213.2. Second, the fragmentation of the medical scheme system can be addressed through the recommended pooling regimes, i.e. the risk adjustment scheme together with social reinsurance and the mandatory minimum package.

214. A further feature of the NHI reform framework is that it implies a misdiagnosis of the current failures of the public and private health systems. Were these failures properly considered, a coherent set of reforms could feasibly have resulted. There are, in fact, no diagnostic studies of any form performed by the NDOH on any part of the health system over the past 11 years relating to the NHI process and framework.

215. As the public sector failures are plainly attributable to weaknesses in the governance framework (see the earlier analysis in this report), and the private sector failures attributable to weaknesses of the regulatory framework (Competition Commission, 2019), there appears to be no imperative to address any actual problems in the health system.

216. Finally, the various references made to other country reforms appear deliberately framed to imply that they are in some way equivalent versions of what is proposed in South Africa through the NHIB. This is not true. While many countries are pursuing UHC reforms, continuously, there are not proposals equivalent to what is suggested for South Africa. No support can be drawn from international experience for the specific NHI framework proposed.

Likely Constitutional challenges

217. Constitutional and associated legal challenges are likely to be successful in relation to the following proposals:

217.1. The re-direction of the PES to the national level of government;

217.2. The circumvention of the powers of provinces, which reduce the health function to that of an agent for the NHIF;

217.3. The establishment of government components without the requisite powers or permissions to do so;

217.4. The prohibition of medical scheme coverage for benefits offered through the NHIF;

217.5. The elimination of social protections offered to medical scheme members through the Medical Schemes Act; and

217.6. The removal of the tax credit regime for contributions to medical schemes, which is an existing legitimate entitlement for a population that cannot in any way be accommodated in the public sector.

Lower risk and feasible alternative reforms

218. The proposed NHIB and its associated reform framework offer no solutions to the failures of the health system. Furthermore, the attempt to implement the proposals will in all likelihood destabilise the current health system and exacerbate existing weaknesses.

219. The approaches outlined below are purposefully strategic and reflect quite different, and more efficient, approaches to pooling and purchasing.

220. A fundamental departure point from the NHI framework, as presently proposed, is the understanding that performance problems are inherently related to weaknesses in the governance framework, and not the purchasing framework.

221. In this respect, it is understood that the purchasing function is subordinate to the governance framework. Efficient forms of planning, organising, procuring and delivering healthcare invariably arise from the incentives resulting from how decision-makers are held to account within organisational hierarchies and, directly and indirectly, to users.

222. All the institutional features that drive incentives to perform therefore arise from the governance framework.

223. Purchaser-provider splits therefore arise organically when they make sense to a particular health authority within their context. Efficiencies do not occur magically through imposed purchaser-provider splits, particularly when they are configured within bad governance structures (i.e. the current framework proposed in the NHIB).

224. Taking the above into account, therefore, a more reasonable pathway toward sustainable improvements in South Africa's UHC framework involves the following:

    224.1. The implementation and institutionalisation of a more coherent system of health transfers at the national level of government. This includes the development of pooling structures to support equitable access to health services in both the public and private sectors.

    224.2. The establishment of a national framework of regional and district authorities to operate at the provincial level of government. (This would in fact be a legitimate use of national legislation).

        224.2.1. This framework of decentralised authorities should involve a combination of decentralisation, supportive accountability structures

(that, inter alia, separate political appointments from delivery structures) and a supportive framework of national transfers to ensure equity goals are achieved.

224.2.2. As part of the decentralisation approach, all major facilities should become autonomous, but subject to oversight and supervision by independent supervisory boards.

224.3. A unified system of critical care should be implemented to ensure universal equal access to emergency care for all residents of South Africa. (The Inter-departmental Task Team on Social Security has assessed this proposal, together with a provisional feasibility analysis).

224.4. The system of medical schemes, together with all aspects of the private health system, should be regulated to remove inefficient forms of competition (through, inter alia, the implementation of risk adjustment, social reinsurance and mandatory minimum benefits), remove barriers to entry for new funders, and require transparency regarding the value-for-money of health insurance cover and healthcare providers. In this regard, a comprehensive reform framework has been recommended by the HMI, which should be fully implemented.

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