The National Health Insurance Bill

Submission by the Helen Suzman Foundation

to the National Assembly's Portfolio Committee on Health

28 November 2019

1. Introduction

The Helen Suzman Foundation ("**HSF**") welcomes the opportunity to make a submission to the National Assembly's Portfolio Committee on Health ("**the Committee**") on the National Health Insurance Bill ("**the Bill**"), as published on 26 July 2019. The HSF, as a non-governmental organisation, has been an active participant in a variety of public interest areas in South Africa over many years. Its essential aim is to promote the rule of law and constitutional democracy in South Africa, with a focus on good governance, transparency and accountability. The HSF has had an interest in the health system for a number of years. A list of our publications on this subject is attached as an annexure to this submission.

The HSF views this submission as a way of making a constructive contribution to the establishment of universal health coverage, which is a subject of major importance for the country. We support the goal of the World Health Organisation standard of quality, affordable universal health coverage and recognise that this is being addressed against the background of the socio-economic injustices, imbalances and inequities of the past, as reflected in the Bill's preamble.

Given the great importance of the Bill to South Africa's welfare in general (including not only the health sector, but also that of social welfare, the country's economy and the state's finances), it is crucial that the planning and legislation required for a project of this nature, is appropriate. However, it is clear that there are extensive gaps and failings in preparations for the National Health Insurance ("**NHI**") to realise universal health coverage. The way in which the Bill is formulated, raises major concerns.

2. Our concerns on the content of the Bill

Our immediate concerns cover a wide range of issues, as the following list demonstrates:

- much attention is paid to the funding and purchasing mechanism of the NHI and very little to the quality of health care to be provided;
- the Bill's lack of detail on major aspects;
- there has been a lack of consultation with the private sector;
- there has been a lack of appropriate and transparent consultation with healthcare practitioners/providers;
- the future role of private medical schemes is not adequately considered or articulated;
- whether the NHI can be financed has been given insufficient attention, yet is a key component;
- no feasibility study has been published;
- the administrative requirements of the NHI are significantly underestimated;
- no governance of the NHI is envisaged outside of the Ministry of Health, and there are no safeguards against mismanagement and corruption in this respect;
- Government's track record of managing state-owned entities and social welfare programmes;
- Government's failure to assess universal healthcare provision in other countries, particularly those at a similar stage of development;
- Government's failure to regulate private health care adequately;
- Government's refusal to acknowledge freedom of individual choice; and
- whether the implications for provinces are constitutionally acceptable.

Each one of these will be dealt with in detail below.

3. Government has misplaced the focus: too much attention on the purchasing mechanism of the NHI and very little on ensuring the quality of health care

We believe that Government's focus is misplaced. The fundamental issue is how the floor level of medical services available to all South Africans can be raised as far as available resources allow.

Instead, Government has focused on the NHI's funding and its purchasing mechanism. The latter, which is to be controlled and managed by Government, underlies the present NHI proposals and has evidently become an *idée fixe.* The focus on the purchasing mechanism at this preliminary stage is premature. Only once the quality and number of medical service facilities and providers (public and private) have been substantially raised, can a proper discussion on a project such as the NHI be commenced. In addressing the purchasing mechanism before quality, Government is effectively putting the cart before the horse. In its current form, NHI is nothing more than a centralised funding and payment system. It is not a health care delivery plan.

Whilst the 2017 White Paper and the Bill mention the need to ensure the quality of health care, it is not at all clear how the NHI is to address this challenge. There is a mention in the 2017

White Paper[1] that health facilities will have to be certified by the Office of Health Standards Compliance ("**OHSC**"),[2] the very same entity whose 2016/2017 Inspection Report revealed the widespread non-compliance of health establishments with applicable norms and standards for healthcare quality. The Bill does empower the Minister to make regulations regarding the relationship between the NHI and the OHSC,[3] but it is clear that simply setting standards does not guarantee compliance. The Bill also includes quality monitoring in general terms in the functions and powers of the NHI.[4] However, in this context it needs to be mentioned that the Auditor-General has found that the Department of Health does not have sufficient monitoring controls to ensure adherence to its internal policies and for purposes of taking corrective action.[5]

The reality is that South Africa is confronted with a health sector which offers unacceptable standards of service in both the public and private sectors (as explained further below) and nowhere is it explained by Government how the NHI will improve the service (quantitatively or qualitatively). This is a staggering omission. The fact that all health care within the NHI's scope is planned to be paid for by Government in terms of the Bill will not on its own solve the quality problem. Technical, staffing and administrative considerations, amongst others, render the quality problem far more complex.

If the thinking behind the Bill is that the NHI will be able to improve the quality of health services by using its muscle as the sole (or main) purchaser of medical services (ie. by refusing to accredit and pay providers who do not conform to minimum standards), it would, at first glance, seem to make sense.

The question logically arises as to whether public (and private) entities will be excluded from the NHI if they do not offer acceptable services. The OHSC reported in its 2016/17 Annual Inspection Report on 851 public sector health establishments, that 62% of these establishments were non-compliant with norms and standards for healthcare quality.[6]

Will this lead to the non-compliant 62% of public health establishments being excluded from the NHI? Is Government prepared to render public health establishments redundant as a consequence of unacceptable standards? These questions arise from the logic of using the NHI to improve the quality of healthcare. We would assume that political realities would suggest that the answer to this must be "no", which effectively undermines the logic behind this approach. If the answer were "yes", it would represent a drastic approach from Government and raises the question as to what Government intends to do with health establishments and personnel that are excluded from the health system. Close them down and fire the personnel? It is difficult to see this happening, but this is one of many instances where it becomes clear that distressingly little thinking has been devoted to the practical implementation of the NHI.

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[1] Department of Health, *National Health Insurance for South Africa*, June 2017.

[2] Established in terms of the National Health Amendment Act of 2013, to ensure that public and private health establishments comply with the required health standards. It is listed as a public entity in terms of the Public Financial Management Act and is funded by moneys appropriated by Parliament. The OHSC regards itself as independent, but the OHSC Board is appointed by the Minister of Health and its CEO is appointed by the Board in consultation with the Minister.

[3] Clause 55(1)(k).

[4] Clauses 10 and 11.

[5] Department of Health, *Annual Report 2017/18*, page 105.

[6] OHSC, *Annual Inspection Report 2016/2017*, page 31, available at http://ohsc.org.za/publications/.

An effective quality control mechanism would, on its own, require very substantial personnel resources. The OHSC in its current form, with a total of 121 personnel posts[7] and an annual budget of R130 million, would be completely inadequate to perform the quality control role for something as extensive as the NHI. This is one of the many instances of the Bill which has not been thought through in an appropriate manner.

In its 2016/17 Report, the OHSC states that the public health sector revealed several areas with deficiencies. Particular note should be taken of the first of its conclusions, which reads as follows:

> "Leadership and management, including operational management, was poor or lacking, leaving subordinates without the required level of supervision, knowledge, competency and support from senior staff, including clinical professionals. Governance structures in the greater number of health establishments were not available, impacting negatively on leadership. Where Governance structures were in place, there was no evidence that they provided oversight to ensure quality care, accountability and good management."[8]

The inadequacy of leadership and management structures in the public health sector is patent; this is a matter of public record.[9]

4. The Bill's lack of detail

The Bill provides a legislative skeleton for later regulations of a very substantial nature, to be promulgated by Government (without the accountability involved in the process of passing bills)[10]. As a result, neither the public nor the health sector is afforded any glimpse of what the final product will look like. This will only become clear on the publication of regulations by the Minister, on a timeline of his/her own choosing and with the content of such regulations to be finalised as he/she thinks fit.

If proposed legislation with such far-reaching consequences, is so devoid of detail which is crucial to understanding its effect, and authorises that missing detail to be promulgated only subsequently through regulations by the Minister (to be done at the latter's sole discretion), then it amounts to providing the Minister with a blank cheque. The HSF submits that this is unlawful.

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[7] OHSC, *Annual Performance Plan 2018/19*, page 11, available at http://ohsc.org.za/wp-content/uploads/APP-2018-19-5bOHSC5d-Approved.pdf.

[8] OHSC, *Annual Inspection Report 2016/17*, page 178.

[9] As examples, see in this regard, a question to the Minister of Health on 16 September 2019 (NW397) in which the Minister replied that a certain hospital in Limpopo had been without a CEO since February 2019. In response to a further question (NW206) the Minister noted that there is a total of 42,926 vacancies in the nine provincial departments. National Treasury notes as follows in its *2019 Budget Review*: "Claims against health departments grew from R28.6 billion in March 2015 to R80.4 billion in March 2018. Over the same period, payments for claims increased from R498.7 million to R2.8 billion. The mounting value of claims puts enormous pressure on provincial health budgets, with departments increasingly forced to divert funding from service provision to pay these claims. Medico-legal claims have risen because of inadequate quality of care, weaknesses in administration (including patient record management and legal capacity), and increasingly litigious behaviour from law firms."

[10] *Rules of the National Assembly, Chapter 13: Legislative Process* notes that the National Assembly may legislate on items set out in Schedule 4 of the Constitution. The Rules only make reference to Bills and are completely silent on the manner in which Regulations are to be addressed.

Section 59(1)(a) of the Constitution provides that the National Assembly "must facilitate public involvement in the legislative and other processes of the Assembly and its committees". In this context, public involvement obviously assumes that for it to be valid, from a constitutional and legal point of view, it has to constitute a process of substance, based on sufficient information being provided to the public. Inadequate information cannot form the foundation of a valid consultation exercise.

Government would need to provide sufficient detail for the public to understand what analysis and planning has been done, how the implementation is envisaged, how the quality of health services will be improved, details of the cost/tax implications and the precise legal and administrative effect the Bill will have on all parties who may be concerned.[11] None of these things has been done, so the conclusion is that the public consultation process is fundamentally flawed. On this basis alone, it is open to legal challenge.

5. Lack of consultation with the private sector

The NHI concept is predicated upon the efficient co-operation of the private health sector, whose resources and expertise are to be made more widely available through the NHI's purchasing structure. It is of utmost importance that there is "buy-in" by the private health sector into the NHI's principles and operational structure, for it to function properly. It is therefore astounding that so little consultation has taken place with the various components of the private sector, in order to lay the groundwork for a collaborative relationship. High profile gatherings under Presidential auspices, which serve the purpose of promoting Government´s own views, cannot be regarded as true consultations. This situation has led to a sense of immense insecurity in many areas of the private health sector, and the potential consequences could negatively affect the South African health sector as a whole.

We are also not aware of any investigation being undertaken into the possibility of a public/private partnership in the health sector. We would encourage such an investigation to be undertaken.

[11] As far as the requirement of "consultation" is concerned, the Labour Appeal Court, (Minister of Higher Education and Training and Another v Business Unity South Africa and Another (JA70/16) [2017] ZALAC 69; (2018) 39 ILJ 160 (LAC) (1 November 2017) at para. 42), quoted the following with approval (from R v Secretary of State for Social Services, Ex parte Association of Metropolitan Authorities [1986] 1 All ER 164 at 167): *'There is no general principle to be extracted from the case law as to what kind or amount of consultation is required before delegated legislation, of which consultation is a precondition, can validly be made. But in any context the essence of consultation is the communication of a genuine invitation to give advice and a genuine consideration of that advice. In my view it must go without saying that to achieve consultation sufficient information must be supplied by the consulting to the consulted party to enable it to tender helpful advice. Sufficient time must be given by the consulting to the consulted party to enable it to do that, and sufficient time must be available for such advice to be considered by the consulting party. Sufficient, in that context, does not mean ample, but at least enough to enable the relevant purpose to be fulfilled. By helpful advice, in this context, I mean sufficiently informed and considered information or advice about aspects of the form or substance of the proposals, or their implications for the consulted party, being aspects material to the implementation of the proposal as to which the Secretary of State might not be fully informed or advised and as to which the party consulted might have relevant information or advice to offer*.'"

6. Lack of clarity on the role which private medical schemes will be able to play

The Bill empowers the Minister to make regulations on a wide variety of aspects.[12] These include the following:

- the legal relationship between the National Health Insurance Fund ("**the Fund**") and health care service providers;
- the relationship between public and private health establishments; and
- the relationship between the Fund and private medical schemes.

In respect of the future role of medical schemes, clause 33 of the Bill provides:

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

"Complementary cover" is defined as

> "third party payment for personal health care service benefits not reimbursed by the Fund, including any top up cover offered by medical schemes registered in terms of the Medical Schemes Act or any other voluntary private health insurance fund."

The way in which these provisions have been formulated leads to genuine confusion, as is shown by the following questions:

- in the case of persons who decide not to register as users of the NHI (and are therefore not entitled to NHI benefits and whose medical costs are therefore not reimbursable by the Fund), does it therefore mean that private medical schemes remain able to cover them in respect of all medical services?
- if a health care service provider or health establishment decides not to register with the Fund, are private medical schemes able to cover their services?[13]
- what will be the effect on the NHI if insufficient private medical practitioners register? Will this mean that the current situation in the private health sector simply continues as a result of a lack of interest in the NHI?

The answer to all these questions would seem to be in the affirmative, but they cannot be answered with any degree of confidence from the manner in which the Bill's provisions have been formulated. It is therefore not surprising that the Bill is causing a large measure of uncertainty and confusion not only amongst health practitioners, but amongst the public at large.

As far as the current degree of cover by private medical schemes is concerned, the details are provided in the findings of the 2018 General Household Survey.[14] These show that out of a total of 9 380 000 persons who benefit from private medical aid cover, 48.65% are Black, 9.15% are Coloured, 7.84% are Indian/Asian and 34.38% are White. Expressed in absolute numbers, and contrary to assertions that are made from time to time in public by Government

[12] Clause 55 of the Bill.

[13] How registration will be monitored is another question, given that the implementation of the Health Patient Registration System under the Pilot Project was hamstrung by a lack of equipment and poor infrastructure. See G:Enesis, *Evaluation of Phase 1 implementation of interventions in the National Health Insurance (NHI) pilot districts in South Africa Final Evaluation Report*, paragraph [15.7], July 2019.

[14] Statistics South Africa, *General Household Survey 2018*, page 117.

representatives, more black people are therefore covered by private medical aid than white people.

However, expressed as a percentage of persons within each individual population group who are members of private medical schemes, a larger percentage of the white population group are members of private medical schemes than is the case with other population groups.

The two statistical comparisons set out above should not be confused.

The Bill and the accompanying memorandum offer no explanation at all as to why an attempt is being made to exclude private medical schemes from continuing to provide cover. This is in itself evidence of irrational conduct on the part of Government.

A much more sensible approach would be to allow private medical schemes to continue to operate. If, as announced by Government, the NHI offers quality services at no cost to the patient, demand for private medical insurance will rapidly decrease. However, Government does not seem willing to follow this approach. We find this attitude unjustifiably coercive and difficult to understand.

7. The NHI's financial implications are not adequately dealt with and complicated by a misconceived "pooling" concept

The Preamble to the Bill states that

> "in terms of section 27(2) of the Constitution the State must take reasonable legislative and other measures, within its available resources, to achieve the progressive realisation of the right of access to health care services;"

However, the Memorandum which accompanies the Bill,[15] offers no estimate of the overall cost of the NHI (apart from some expenses of an initial nature). Section 27(2) of the Constitution makes it clear that the obligation of the State to provide health care services is subject to its available resources. If we do not know what NHI will cost; how can we know whether it will be accommodated by the State's available resources? If it cannot be accommodated within its available resources, then the State has no constitutional obligation in this regard. In fact, it has a constitutional duty not to spend beyond its means. The financial implications of the Bill are not answered in an adequate manner in its accompanying memorandum.

The fact that the State has no estimate of the overall costs, is confirmed by recent statements, some of them of a surprisingly flippant nature. Dr Nicholas Crisp, a consultant to the Ministry of Health, has said the following:

> "how long is this going to take? The answer is a long time. ….. We don't know all the details of what it will look like in the end. What we do know is we are going to have to be flexible. What is it going to cost? It's going to cost as much as we can afford."[16]

[15] Para. 8, Financial Implications for the State

[16] Remarks made during a panel discussion on the NHI at the Mandela Institute of the of the School of Law at the University of the Witwatersrand, 11 September 2019. For the live stream of the event, see: https://www.youtube.com/watch?v=n7Hq0BE5acQ&t=2869s

Other comments include those by Dr Olive Shisana, special advisor on social policy to the President, who has stated that

> "The demand that the NHI Bill should indicate costs is unfair because costs change over time."[17]

It is not rational to proceed with a project of these dimensions in the absence of cost estimates which are based on a comprehensive project analysis. The cavalier way in which the cost of the NHI is dealt with in public, seems to have its roots in the conceptual confusion caused by the concept of the "pooling" of funds to finance the NHI. This relates to the idea that public health expenditure (funded by Government) and private health expenditure (funded by private medical schemes) can be "pooled" to fund the NHI. This concept appears in the 2017 White Paper and often appears elsewhere in published Government material and in Government statements. However, what the Bill envisages is something quite different: the NHI is to be funded by Government from increased tax revenue - since there is no way in which private medical aid premiums can simply be appropriated by the State and redirected as it wishes.

The way in which the concept of the "pooling" of financial resources has been presented, implies that Government is of the opinion that any moneys outside of the "pooled" resources cannot be used as premium payments for private medical aid. This assumes that taxpayers who pay increased tax to fund the NHI, are not allowed to use their after-tax income to pay for private medical aid premiums. If this thinking forms the basis of Government's theory on the NHI, then it is illogical in the extreme. The absurdity of this logic becomes even more acute when one asks the question whether patients are permitted to pay for services from their own pockets - this seems to be allowed, but not as payment for premiums to belong to private medical aids that offer comprehensive cover.

Government is therefore intending to prevent taxpayers who pay increased taxes as their contribution to fund the NHI, from exercising their freedom to choose whether to insure themselves independently from the NHI. It is attempting to force tax-compliant individuals to make use of the NHI by legislatively prohibiting any insurance-financed alternatives. No justification for such a prohibition has been provided. There is also no logical connection between the prohibition on privately funded medical aid schemes and the implementation of an NHI which is funded by taxpayers. The funding of these two separate entities have nothing to do with one another. This proposed legislation can therefore only be regarded as arbitrary and irrational conduct by the State and as such, amounts to an unconstitutional use of its legislative power.[18]

How is an attempt to prevent consumers from being able to have access to private medical schemes, constitutionally acceptable, if those consumers pay increased taxes to fund the NHI? To take the question further in order to show its inherent irrationality: how can the Bill attempt to prevent private individuals who effectively fund the NHI through their taxes, from paying out of their own pockets for whatever medical service they require, without making use of the NHI?

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[17] Quoted in *BusinessTech*, 22 August 2019.

[18] In Poverty Alleviation Network and Others v President of the Republic of South Africa and Others (CCT86/08) [2010] ZACC 5; 2010 (6) BCLR 520 (CC) (24 February 2010) the Court held at para 65 that "The principle that every law and every exercise of public power should not be arbitrary but rational has been developed by this Court in a series of judgments."

These questions raise issues concerning the concepts of freedom of association and freedom to contract, which the State can only limit in very specific circumstances. No justification is provided in the Bill or the associated documentation for limiting the ability of private medical schemes to provide cover to their members.

In respect of financing the NHI through Government tax revenue, a final comment must be added: the Bill provides for certain Government revenues to be earmarked for NHI funding.[19] It is normal practice for National Treasury to avoid such earmarking, as it ties its hands in apportioning departmental budgets. If one department is seen to have a special deal in this regard, other departments will try to do the same, complicating the whole budget process.

8. Absence of a feasibility study

The functions of the NHI, as set out in clause 10, include the following:

- attain universal health coverage;
- purchase health care services on behalf of users (potentially the whole SA population);
- enter into contracts with accredited health care service providers;
- determine payment rates to health care service providers annually;
- ensure that appropriate funding is in place;
- monitor the quality of health care services;
- maintain a service and performance profile of all accredited and contracted health care service providers;
- undertake internal audit and risk management; and
- maintain a national database of demographic and epidemiological profile of the population.

These functions constitute a project of massive proportions, to be managed by an organisation which is to be established from scratch. In the case of start-up ventures of this magnitude and complexity, it is standard practice for a feasibility study to be conducted, including a detailed financial analysis and forecast. It is inconceivable that projects of such dimensions would even be considered in the private sector without a comprehensive feasibility study. The purpose of such a feasibility study is to plan and facilitate the start-up process by highlighting issues that may require special attention, by emphasising specific risks and by ensuring that the required financial resources are available.

Feasibility studies would include various financial scenarios, to illustrate the consequences of specific policies or decisions. In order to obtain a better understanding of the financial implications of the NHI, a feasibility study should ideally assume several scenarios, depending on the level of cover to be provided. One could therefore see what the cost would be for various levels of cover, whether of a minimum, intermediate or maximum nature - and plan according to what is financially feasible. This has not been done.

In the specific circumstances of the NHI, one of the important roles which a feasibility study could play, is to determine how the private and public sectors can effectively operate within a single payment or funding structure to be provided by the State. Inadequate details have been provided on how this effective putting together of the private and public sectors is to work in practice.

[19] Clause 49.

The 2017 White Paper on the NHI refers to the first phase of the NHI (2012 to 2017), but apart from a few general comments, makes no mention of what was actually achieved in that initial phase. In this context, the Minister has confirmed in Parliament[20] that certain pilot projects (which have sometimes been referred to as NHI pilot projects) were not NHI pilots but projects intended to improve the public health system. In that same reply, he stated that "the NHI policy was finalised after widespread research and consultation with local and international experts prior to its finalisation". However, no details are available of the research and consultation to which he was referring.

In the final analysis, it is irresponsible in the extreme to try to run project of this magnitude and complexity without an extensive feasibility study and an associated costing exercise. Otherwise, the State is effectively flying blind - as reflected by Dr Nicholas Crisp's comment which is quoted above. It hardly needs mentioning that if it is not at all clear what the NHI will cost, how can it be estimated by how much tax revenue will have to increase in order to fund it? Is it feasible or realistic to increase taxes to the levels that may be required? As a result of the lack of estimates on the cost of the NHI, nobody knows.

Three months after the publication of the Bill, on the occasion of the Minister of Finance's Medium Term Budget Policy Statement in Parliament on 30 October 2019, National Treasury's comment on the financing of the NHI, reads as follows:

> "…. given the macroeconomic and fiscal outlook, the estimates to roll out NHI that were published in the NHI Green Paper in 2011 and White Paper in 2017 **are no longer affordable**."[21] (emphasis added)

It is surprising that neither the Minister of Health nor his Department have as yet commented on this statement by National Treasury. What is proposed in the Bill has evidently been done without including National Treasury's opinion on its affordability (or even consciously disregarding it) - given the lack of analysis and planning for its implementation and operation, coupled with a refusal to accept National Treasury's view that it cannot be funded, can only lead to one conclusion: it cannot constitute a rational project.

9. The NHI's administrative requirements

If we assume that there will potentially be around 58 million users (ie. the whole South African population), and if we add to that 221 508 healthcare practitioners[22] and 814 public and private healthcare facilities,[23] it is evident that what is proposed for the NHI represents a huge administrative task.

The Government will have to allocate funds to the NHI in the Budget each year, but no mention is made in the Bill of a mechanism to align the services to be covered by the NHI to the budget for funding it - in other words, how to make sure that there is enough money to finance the scope of services to be paid by the NHI. If there is insufficient funding, some healthcare services will have to be excluded. This will require a constant effort on the part of the NHI's specialised committees and administrators and underlines the administrative burden of managing

[20] Answer to a question in the National Assembly, 2 September 2019.
[21] National Treasury, *Medium Term Budget Policy Statement*, 30 October 2019, page 37.
[22] Health Market Inquiry, *Final Findings and Recommendations*, September 2019, page 45.
[23] Health Market Inquiry, page 46.

something like the NHI. A large, suitably qualified staff component will therefore have to be available to deal with the functions of the NHI.

From the content of the Bill, it is clear that Government has not understood the difficulties of implementing the NHI and continues to underestimate the challenges that it faces. Our view is supported by the presentation by the Financial and Fiscal Commission ("**FFC**") to the Portfolio Committee on Health on 9 October 2019.[24] The FFC's briefing contained the following:

- the 2026 timeline for full implementation of the NHI is too short a target to complete all the necessary steps;
- outstanding issues include the establishment of operational and administrative capacity and costing; and
- critical details which are fundamental to a successful rolling out of the NHI remain unspecified - these include the role of provinces, the flow of funds between the Fund, provinces, districts and private providers, financing of health infrastructure and the ownership structure of public health facilities.

Recent examples of serious managerial and operational incompetency in State entities do not provide any confidence whatsoever in Government's intentions regarding NHI. The crisis confronting the South African Social Security Agency ("**SASSA**") in 2017 provides a salutary lesson in this regard. Following the Constitutional Court's declaring a tender award for the payment of social grants invalid, SASSA reported to the Court in November 2015 that it had decided not to award a new tender, but would itself take over the payment of social grants before the deadline of March 2017. However, SASSA underestimated the difficulties of implementing such a payment system and became aware in April 2016 that it could not comply with this undertaking. The Minister was informed in October 2016, but SASSA then approached the Court with this news only in February 2017, leading to a last-minute order by the Constitutional Court to extend the operation of an invalid contract in order to avoid grants not being paid. The only additional comment that we can make in the context of this example is that the SASSA payment mechanism is simple and uncomplicated in comparison to implementing the NHI.

10. Governance

The Bill provides that the Minister of Health is responsible for all aspects relating to the governance of the national health system. The Minister is to appoint a Board to govern the Fund,[25] which is to be accountable to the Minister himself.[26] The Minister must appoint a Chairperson from among the members of the Board.[27] A Chief Executive Officer is to be appointed by the Minister, on recommendation of the Board and is directly accountable to the Board.[28] The Minister may remove a Board member.[29] A Benefits Advisory Committee and a

[24] https://www.ffc.co.za/images/Briefing_to_PC_on_Health_9_october_2019.pdf. The FFC was established in terms of Section 220 of the Constitution, which provides that it is to be independent and subject only to the Constitution and the law and must be impartial. Its focus is primarily on the equitable division of nationally collected revenue among the three spheres of Government.
[25] Clause 13(1).
[26] Clause 12.
[27] Clause 14(1).
[28] Clause 19(1).
[29] Clause 13(8).

Health Care Benefits Pricing Committee are to be appointed by the Minister after consultation with the Board.[30]

Clause 27 of the Bill provides that a Stakeholder Advisory Committee is to be appointed by the Minister after consultation with the Board, to comprise representatives of statutory health professions councils, health public entities, organised labour, civil society organisations, associations of health professionals and providers and patient advocacy groups. However, this Stakeholder Advisory Committee is accorded no duties or responsibilities and what it is supposed to do is left hanging in the air. There is no obligation on the Minister or Board even to consult it.

There is therefore no independent oversight envisaged and all power is effectively concentrated in the Minister. Given the well-known consequences in South African state-owned entities resulting from a lack of governance, little accountability and widespread financial mismanagement, this is not acceptable. The poor oversight by Government of state-owned entities in general is confirmed beyond doubt by the most recent Auditor-General's report on national and provincial audit outcomes,[31] which was made public on 20 November 2019. The following is taken from that report (where "**SOEs**" denotes state-owned enterprises):

> "None of the SOEs managed to obtain a clean audit opinion"[32]
>
> "The overall audit outcomes of the SOEs are the worst they have ever been"[33]
>
> "The root causes of the regression in the overall audit outcomes of SOEs were weak internal control environments, instability in appointed senior management positions, and a lack of implemented action plans to address previously reported audit findings."[34]

Statements which attempt to refute the risks in this regard, such as those by Dr Olive Shisana,[35] therefore cannot be taken seriously: she states that many public entities run very well, but then only mentions institutions such as the CSIR and the Council of Geoscience. She does not seem to realise that such statements effectively undermine the very argument she is trying to make. The institutions she mentions are all long-established organisations which cater for niche markets with very specific technical standards - and they are insignificant from a financial point of view, when compared to something of the size of the NHI.

Her comments also include the following: "… NHI will not be a state-owned entity, but more of a public entity that operates under the Public Finance Management Act, audited by the Auditor General."

Once again, statements of this nature, with unconvincing denials, simply reinforce doubts about what is actually intended in the NHI project.

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[30] Clauses 25(1) and 26(1).
[31] PFMA 2018-19, Consolidated General Report on national and provincial audit outcomes, Auditor-General of South Africa.
[32] PFMA 2018-19, page 13.
[33] PFMA 2018-19, page 114.
[34] PFMA 2018-19, page 139.
[35] *BusinessTech*, 22 August 2019

11. The findings of the Health Market Inquiry into the private healthcare sector

The findings of the Health Market Inquiry ("**the Inquiry**") into the private South African healthcare market were published on 30 September 2019.[36] In the first paragraph of the Inquiry's report, it is stated that

> "In our review of the South African private healthcare market we found that it is characterised by high and rising costs of healthcare and medical scheme cover, and significant overutilization without stakeholders having been able to demonstrate associated improvements in health outcomes."[37]

Other major findings of the Inquiry are:

> "We have found there has been inadequate stewardship of the private sector with failures that include the Department of Health not using existing legislated powers to manage the private healthcare market, failing to ensure regular reviews as required by law, and failing to hold regulators sufficiently accountable. As a consequence, the private sector is neither efficient nor competitive."[38]

> "For effective and efficient regulatory oversight of the supply-side of the healthcare market, we recommend the establishment of a dedicated healthcare regulatory authority, referred to here as the Supply Side Regulator for Healthcare (SSRH)."[39]

> "… irrespective of the final formulation and timing of the NHI, having a cost-effective, competitive and appropriately regulated supply of private healthcare services, will support the development of the NHI."[40]

The Inquiry therefore found that in respect of the private healthcare sector, the State itself has failed in its duty to regulate the sector in an adequate manner. In spite of its demonstrated inability to regulate the private healthcare sector, Government now intends to include it within the ambit of the NHI - unless any private healthcare service decides to remain outside.

We are surprised that the Bill was published before publication of the Inquiry's final report. As a consequence, the impression cannot be avoided that Government did not consider it relevant for the Bill's provisions. This once again raises questions about the rationality of Government's action in respect of NHI and the Bill.

12. How does the Bill affect the provinces?

In terms of the Constitution,[41] both Parliament and the provincial legislatures are empowered to pass legislation on health services. In the case of conflict between national and provincial legislation, national legislation prevails over provincial legislation, only when, *inter alia*:[42]

- the matter cannot be regulated effectively by provinces individually;

[36] Available at http://www.compcom.co.za/wp-content/uploads/2014/09/Health-Market-Inquiry-Report.pdf.
[37] Health Market Inquiry, page 1.
[38] Health Market Inquiry, page 30.
[39] Health Market Inquiry, page 35.
[40] Health Market Inquiry, page 210.
[41] The Constitution, Sections 44, 104 and Schedule 4.
[42] Section 146.

- the matter requires uniformity across the nation;
- the legislation is necessary for the promotion of equal access to government services; and
- national legislation is aimed at preventing unreasonable action by a province that is prejudicial to, amongst others, the health interests.

If these conditions do not apply, then provincial legislation prevails over national legislation.[43]

As far as a province's executive power is concerned, it is vested in its Premier,[44] who implements that province's provincial legislation and all national legislation that is applicable.[45] The national executive may only intervene in provincial administration when a province cannot or does not fulfil an executive obligation in terms of the Constitution or legislation.[46]

The Constitution provides that an Act of Parliament must provide for the equitable division of revenue from the national budget among the national, provincial and local spheres of government (generally referred to as "equitable shares").[47] This has to be done by way of an Act of Parliament, which may only be enacted once the FFC has been consulted and after having taken into account any of the FFC's recommendations. In this regard, the national interest and a wide range of other considerations have to be taken into account. The purpose of the equitable share is to provide provinces and local government with funding to enable them to perform basic services and perform the functions that have been allocated to them.[48]

The National Health Act, 61 of 2003 ("**NHA**") provides the foundational structure of the national, provincial, and district health care system. The Bill's provisions include amendments to the NHA relating to the duties of provincial health authorities, by deleting or altering many of their functions, in favour of a more expansive role for the national Department of Health.

The question arises whether the effect of the Bill of drastically reducing provincial equitable shares (because central government is taking over much of their health functions) is constitutionally permissible.

13. Conclusion

While we support the underlying concept of universal health care, we believe that insufficient information has been provided to enable a lawful public consultation. In addition, grossly inadequate research, planning and analysis, concerning the operational, administrative and financial aspects of the NHI, have led to a Bill which cannot be considered to be the product of a rational process. National Treasury's opinion that it cannot be funded as envisaged, provides further concrete evidence of an exercise which is glaringly irrational.

Government has been unable to manage the public health sector in an acceptable manner and at the same time, has also shown itself to be unable to regulate the private health sector. In addition, it has shown itself to be incapable of managing many State entities in a satisfactory manner. Government now proposes to establish an NHI which will control and manage most of the health sector, and which is intended to serve as the single purchaser and single payer of

[43] Section 146(5).
[44] Section 125(1).
[45] Section 125(2).
[46] Section 100.
[47] Section 214.
[48] Section 227.

health care services from both the public and private sectors. It makes no sense to try to integrate these two segments of the national health sector into one consolidated purchasing framework, if there is no clear plan to address their respective shortcomings.

Government has not explained how the NHI will ensure health services of an acceptable quality. It has not completed a feasibility study for this massive enterprise and is unable to provide an estimate as to what it will cost. It is therefore impossible to estimate the increase in tax that is required to fund it and the Bill and the accompanying memorandum do not provide adequate detail as to how Government proposes to implement, fund and run the NHI in an efficient manner.

Another fundamental defect of the Bill and its accompanying memorandum is that no justification is presented for the attempt to exclude private medical schemes from the greater part of the South African health sector. It is illogical to expect patients to fund the NHI through increased taxes, but then at the same time to remove their freedom of choice if they want to continue to use private medical aid for their needs, to be funded from their personal after-tax income.

Government also continues to underestimate the complexity and scale of establishing the NHI and will not be able to keep to the timeline of implementing it by 2026. An overly hasty attempt to get the NHI up and running, can only cause further damage to the country's health system. In the context of a highly constrained fiscal situation, the risk is that the substantial costs of re-engineering the health system may mean that real *per capita* Government expenditure on the provision of health care may actually drop.

What therefore needs to be done, if universal health coverage is to be pursued?

- first of all, a properly functioning public health service has to be put in place, and here it is in the first place, issues of management and accountability that have to be addressed, rather than financial ones;
- secondly, a private sector health service that is properly regulated by Government;
- thirdly, the private sector needs to be consulted in a substantive manner on the NHI, in order to approach the project in a collaborative manner, as a lack of co-operation and commitment by the private sector will effectively torpedo the implementation of the whole NHI structure. A new system can only succeed with the consent and support of health care service providers and it is naïve of Government to imagine otherwise; and
- fourthly, clarity has to be obtained as to the cost of the NHI and confirmation from National Treasury that the project is affordable.

Once these goals have been achieved, the NHI can be reconsidered. In effect, the Bill and the comments by persons who are responsible for its implementation, are creating the impression that the NHI is being invented as it goes along. As a consequence, the NHI project has led to a great deal of insecurity amongst the South African public in general, and in particular, professionals and employees in the health care sector (both public and private).

The effect of the way in which the NHI project is being driven by Government should not be underestimated: any attempt to deal with a major project such as the NHI in a manner which lacks credibility, will inevitably have a detrimental effect on the perception of Government's general ability to deal with a challenging economic and financial situation. It is not the principle of universal health coverage which is the problem, but the manner in which Government is trying to implement it. As a result, further damage will be done to business confidence, which is

a crucial element in investment decisions and ultimately, in driving economic growth and increasing employment. In the fourth quarter of 2019, the RMB/BER Business Confidence Index was at its lowest point since 2009.

In our view, the Committee has been presented with the thankless task of having to deal with a draft piece of legislation which is the result of an irrational process, which is seriously defective and which will cause yet more damage to an already struggling health sector.

We therefore recommend that the Bill be withdrawn.

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Annexure

Research and comment on the SA health system published by the Helen Suzman Foundation

1. Strategic Health Reform – Round Table (Dec 01, 2009) (https://hsf.org.za/publications/roundtable-series/issue-thirteen-december-2009).
2. Submission to National Department of Health - National Health Insurance Green Paper (Dec 16, 2011) (https://hsf.org.za/publications/submissions/nhi-green-paper-submission.pdf).
3. Desperately Seeking Health Reform - Is 'NHI' the answer? (Feb 07, 2012) (https://hsf.org.za/news/hsf-articles/desperately-seeking-health-reform-is-nhi-the-answer).
4. The NHI is an Opiate not a Cure (Mar 27, 2012) (https://hsf.org.za/news/hsf-articles/the-nhi-is-an-opiate-not-a-cure).
5. No such thing as NHI (Jun 05, 2012) (https://hsf.org.za/news/hsf-articles/no-such-thing-as-nhi).
6. Council for Medical Schemes News: What is Troubling South Africa's Health System? (Apr 12, 2013). (https://hsf.org.za/news/hsf-articles/council-for-medical-schemes-news-what-is-troubling-south-africas-health-system).
7. Submission to National Department of Health - The White Paper on National Health Insurance for South Africa (Sep 15, 2016) (https://hsf.org.za/publications/submissions/nhi-white-paper-submission.pdf).
8. Enquiry into Pharmaceuticals in South Africa (2016) (https://hsf.org.za/publications/special-publications/pharmaceuticals-in-south-africa/pharmaceuticals-in-south-africa-an-enquiry-2).
9. Report of Supply of Pharmaceuticals in South Africa (2018) (https://hsf.org.za/publications/special-publications/pharmaceuticals-in-south-africa/pharma-report-2018.pdf).
10. Submission on National Health Insurance Bill and Medical Schemes Amendment Bill (Sep 26, 2018) (https://hsf.org.za/publications/submissions/hsf-submission-on-nhi-bill-and-msaa-bill.pdf).
11. Numerous Briefs regarding various health related issues (2013 – ongoing) (https://hsf.org.za/publications/hsf-briefs/by-category – under the "Health" tab).