South African Institute of Race Relations NPC (IRR)
Submission to the
Department of Health
regarding the
White Paper on National Health Insurance
for South Africa (Version 40)
Johannesburg, 25th May 2016

Contents

Introduction

The Department of Health has invited interested people and stakeholders to submit written comments on the White Paper on National Health Insurance for South Africa, Version 40, published on 10 December 2015 (the White Paper) by 31st May 2016.

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

According to the White Paper, 'National Health Insurance (NHI) is a health financing system that is designed to pool funds to provide universal access to quality, affordable health services for all South Africans, based on their health needs and irrespective of their socio-economic status.' The new NHI system will be implemented through 'the creation of a single fund that is publicly financed and publicly administered', while 'the health services covered by NHI will be provided free at the point of care'. [Para 51, White Paper]

This description emphasises the many advantages the NHI system is supposed to bring about. In practice, however, NHI will reduce access to health care. It will also impose a crippling financial burden on a struggling economy already standing on the brink of recession.

The proposed NHI system is premised on a number of flawed assumptions. It overlooks many of the gains already made in managing the heavy burden of disease confronting South Africa. In addition, it disregards key reasons for the poor performance of the public health care system. These failings make for a skewed diagnosis of health care problems, leading to a skewed assessment of how these problems can be overcome.

Rationale for the NHI proposal

A two-tier health system

The White Paper repeatedly describes the health care system in South Africa as 'a two-tiered system divided along socio-economic lines'. It identifies this as the primary reason for 'inequity' in health care provision, saying: 'The main contributor to inequity in health care is the existence of a two-tier healthcare system where the rich pool their health care funds and

resources separately from the poor.' According to the White Paper, the two-tier system has also resulted 'in mal-distribution of key health professionals between the public and private health sectors' as 'scarce health professionals naturally migrate towards the private health care system which is better resourced financially relative to the population it serves.' [Paras 5, 77, White Paper]

The White Paper, like the Green Paper on the NHI before it, thus assumes that a 'two-tier' health system, including both public and private health care services, is the key reason for the poor performance of the entire health care system. It further assumes that poor performance in the public service is primarily the fault of the private sector. But the main problem with public health care is that the resources available to it are poorly managed and often wasted, as further described below. By contrast, the efficient private health care system is hugely beneficial to all South Africans, including the poor.

The solution to the many weaknesses in public health care is not to weaken or destroy private health care, as the White Paper envisages, but rather to increase access to the private system, which most people prefer, in a variety of way (see *Alternatives to the NHI*, below). The public system also has much to learn from the private system in improving its own performance. It could also harness many of the private system's strengths by contracting with the private sector to manage and administer the 84% of public hospitals and clinics that are currently unable to comply with the government's own health standards.

An alleged 'mal-distribution' of health care professionals

The White Paper further assumes that the private health care system poaches health care professionals from the public system, so resulting in a 'mal-distribution' of resources between the two. [Para 77, White Paper]

However, this 'mal-distribution' is less acute than the White Paper suggests. In 2015, 45.3% of general practitioners (GPs) and specialists worked in the public sector, which is close on half the total number. Among professional nurses, more than half (51.2%) worked in the public sector, while the situation was similar for nursing assistants (49.5%) and enrolled nurses (46.5%). [IRR, *South Africa Survey*, 2016 (2016 *Survey*), p572]

Among specialists, 41.5% currently work in the public service, while 58.5% practise privately. However, among family physicians, forensic pathologists, and public health medicine, there are more specialists in the public service than there are in private practice. In addition, specialists engaged in emergency medicine are equally split between the public and private spheres, as are paediatricians, physicians, surgeons, and radiation oncologists. [Dr Johann Serfontein, 'Unanticipated Operational Complexities in the NHI', Presentation to the Free Market Foundation, Johannesburg, 20 April 2016]

It is also not the fault of the private sector that more specialists choose to work there than in the public service. First, the government's increasing focus on primary health care has resulted in a major shift in funding away from public tertiary hospitals, which has left many

specialists with little choice but to turn to private practice or leave the country. Persistent mismanagement in the public sector has also helped to drive out specialists and other health care professionals, as has the government's flawed handling of the HIV/AIDS crisis. A lack of suitable equipment also contributes to the exodus from the public service, as does the risk of violent crime in poorer areas. [Serfontein, FMF presentation, 20 April 2016]

Moreover, the main problem is not that there are too many specialists in the private sector but rather that there are too few health care professionals overall. Mistaken policies play a key part in this shortfall too. One of the key problems is the government's refusal to allow private institutions to train doctors. [*City Press* 13 March 2016] Yet if this were permitted, private institutions could be established on either a for-profit or non-profit basis and could play a major part in alleviating the current shortage. The country's private hospitals are centres of excellence and world-renowned for their high levels of care. Hence, privately-run education facilities, working together with private hospitals, could attract internationally recognised teaching staff and provide high quality training that would attract both local as well as international students.

Instead, the burden of training new doctors continues to rest solely on the country's public universities, which for many years have had the capacity to train only some 1 300 new doctors a year (a total first reached in the 1970s). Though the number being trained at these institutions is now being pushed up to some 1 900), there has been little matching increase in the resources made available to universities for this purpose, so undermining the quality of the tuition provided. In addition, this increase is still too limited to meet the needs of an expanding population with a growing burden of disease and high numbers of trauma cases. In addition, the number of specialists being trained in public hospitals has declined in recent years, mainly because of budgetary constraints. Hence, whereas 165 specialists were trained by the KwaZulu-Natal health department in 2013, only 39 were trained in 2014. [*Sunday Times* 5 April 2015, *The Times* 8 February 2016]

The Department of Health also continues to restrict the supply of doctors by limiting the number of foreign health professionals entering South Africa. It has tried to rectify the shortfall by sending close on 3 300 medical students to train in Cuba, but those selected for study there need only a minimum of 50% in English, mathematics, physical science and life science, whereas South Africa's own universities have far more demanding admission requirements. Some 440 students have qualified in Cuba and are now back in South Africa and working in rural areas. However, doctors trained in Cuba have little experience of local conditions. They must also do a further two years' training in South Africa to complete their studies, adding to the already high costs of the training programme and adding to doubts about its overall efficacy. [*Sunday Times* 5 April 2015]

Since 2008, moreover, the public service has put its focus on hiring administrative staff, rather than medical personnel. As a result, the number of 'core administrative' staff employed in the public sector went up from some 33 330 in 2012 to roughly 37 330 in 2015, an increase of some 12%. At the same time, the number of doctors shrank slightly (from 19 422 to

19 352). This has resulted in doctors being outnumbered by administrative staff by two to one. [*Business Day* 9 February 2016]

The situation is also likely to worsen, says the South African Medical Association (SAMA), because medical posts have been frozen in five provinces (Eastern Cape, Free State, KwaZulu-Natal, Mpumalanga, and North West). This is being done in an attempt to reduce the rapidly growing public service wage bill, which has gone up by more than 80% since 2008. [*The Times* 8 February 2016; *fin24.com*, 20 May 2015]

According to Daygan Eager, spokesman for the Rural Health Advocacy Project, the government plans to cut as many as 20 000 jobs and impose a 'lock' on its payroll system to prevent provincial administrations from making unapproved new hires. The finance minister, Pravin Gordhan, has said that frontline health care staff will not be affected by the state's drive to cut the public service wage bill by R7.2bn over the next three years, while the Department of Health has also denied that medical posts have been frozen. However, says Mr Eager, there remains a risk that provincial health departments may cut clinical positions 'by stealth': for example, by delaying filling vacant posts when medical professionals leave. [*The Times* 8, *Business Day* 29 February 2016]

These implicit moratoria on hiring, adds Mr Eager, have been 'driven largely by dramatic eight percent year-on-year salary increases for public sector health staff over the last decade'. In this period, provincial health budgets have grown by only some two percent a year. As a result, 'employee compensation now accounts for about 65% of provincial health expenditure'. In addition, provincial health budgets for 2016/17 are R9bn short of what is needed to sustain salaries. [Health-e News: The Big Chill: Health post freeze threatens services, *The Daily Maverick* 1 February 2016]

The government also curtailed the training of nurses in the mid 1990s by closing a number of nursing colleges. Though it has since pledged to reopen these, little progress has yet been made. Despite private sector efforts to fill the gap (private institutions now train more than half of the registered nurses who qualify in South Africa), the government's own actions have contributed to a critical shortage of nurses, especially in specialist areas such as intensive care. [*The Citizen* 19 February 2015, *The New Age* 12 May 2016]

According to Simon Hlungwani, president of the Democratic Nursing Organisation of South Africa (Denosa), 'nurses work under harsh conditions', with two or three nurses often having to do the work of four or five. Adds Mr Hlungwani: 'If there are only three nurses in a 20-bed maternity hospital and ten patients become critical at the same time and someone dies because there was no hand to help her, that blame is squarely put on the three nurses… This is driving nurses slowly out of government employ.' [Health e-News, ibid]

Though some 136 400 nurses work in the public health care system, in 2015 the national Department of Health estimated that another 44 800 were needed. According to Professor Laetitia Rispel, head of the School of Public Health at the University of the Witwatersrand,

provincial health departments do not plan well enough for patient loads and fail to act against staff absenteeism, which means they often have to turn to nursing agencies to fill gaps in their nursing staff. As a result, between 2009 and 2010, the government spent some R1.5bn on hiring nurses for the public sector from these agencies. Many of these nurses already had jobs in the public or private systems. Close on 70% of nurses (among the 3 784 nurses interviewed across four provinces) were 'moonlighting, working overtime, or doing agency nursing… Of these, one fifth did all three'. This meant that many nurses were working excessive hours and were too tired to perform well on duty. [*Business Day* 2 July 2015, 9 February 2016]

Health care should not be 'commodified'

The White Paper also states that 'health care should be seen as a social investment and therefore should not be subjected to market forces where it is treated as a normal commodity of trade'. [Para 4, White Paper]

However, it is 'market forces' that create competition in the private health care system, thus improving efficiency and accountability and helping to hold down unit costs. This explains why South Africa's private health care system is so much more effective than the public one – and why South Africa's private health care system was rated seventh-best in the world in 2009, whereas an international poll of public hospitals that same year saw the country's public health sector as 'languishing among the bottom three in the world'. [*The Star* 6 July 2009]

This differential also explains why millions of South Africans, including those without medical aid, prefer to pay to see private practitioners, rather than rely on low-cost but poorly functioning state clinics and hospitals. Poor South Africans should not be deprived of this choice via the NHI system.

Instead, the key needs are to improve the quality of public healthcare, while increasing access to private health care for those unable to afford it (see *Alternatives to the NHI*, below). The private sector should also be allowed and encouraged to take on the management of failing public health-care institutions so that these can become as efficient as South Africa's already world-class private health facilities. If this could be achieved, many people might then prefer to use the public health care system, rather than the private one. Unless and until this happens, however, South Africans should not be deprived of the option of seeking effective medical help from private practitioners.

Out-of- pocket payments

The White Paper criticises the 'out of pocket' payments that millions of South Africans must make when they seek health care services from either the public or the private sectors. [Para 85, White Paper]

The White Paper notes that primary health care in the public service is free of charge. At higher levels of care, children under six years of age, along with pregnant women, the disabled, and the indigent are exempt from paying user fees. The National Health Act of 2003

also allows for free health care to be extended to other categories of users. However, only half of these eligible for exemption in fact receive it. In addition, people who use public hospitals and earn above a specified level (roughly R6 000 a month) are obliged to pay a fee under the Uniform Patient Fee Schedule. Fees paid on this basis average around R450 million a year. [Para 87, White Paper; *Financial Mail* 13 August 2015]

In the private sphere, people who do not belong to medical schemes but nevertheless prefer to seek private health treatment pay the necessary fees out of their own pockets. So too do medical aid members who have exhausted their annual benefits. In addition, medical aid members are often obliged to make co-payments for medical fees that exceed the tariff applied by their schemes. The White Paper criticises these co-payments, saying they are used 'as a deterrent to service use and as a cost-containment (demand-management) measure'. According to the international evidence, it adds, such payments 'disproportionately deter use for the most vulnerable, particularly the lowest socio-economic groups, and thereby entrench inequalities in access to and use of needed health care'. [Para 86, White Paper]

However, international comparison shows that co-payments in South Africa make up only a small proportion of total health expenditure in the country. According to the *World Development Indicators 2015* compiled by the World Bank, out-of-pocket payments in South Africa make up 7.1% of total health expenditure, whereas the equivalent proportions in the BRIC countries are 29.9% in Brazil, 48.0% in Russia, 58.2% in India, and 33.9% in China. The South African proportion is also far lower than that in many other emerging countries, including Egypt (58.0%), Indonesia (45.8%), Mauritius (46.5%), Pakistan (54.9%), the Philippines (56.7%) and Sri Lanka (46.5%). [2016 *Survey*, p569]

The South African proportion, at 7.1%, is in fact the lowest among all emerging markets assessed by the World Bank. It is also much lower than equivalent proportions in other African countries, including Angola (24.4%), Cote d'Ivoire (51.2%), Ghana (36.2%), Kenya (44.6%), Nigeria (69.3%), and Tanzania (33.2%). Of all African countries, only Mozambique has a lower proportion, at 6.4%, but its health facilities are not comparable with the range and quality of those in South Africa. [2016 *Survey*, p570]

Though the White Paper implies that out-of-pocket payments are as much a problem in South Africa as they are in other countries, this is not in fact the case. It is nevertheless important to find ways of helping people to fund such payments, especially as they could, in instances of severe illness or injury, have catastrophic financial consequences for households. However, this goal can be achieved without introducing the NHI system (see *Alternatives to the NHI*, below).

The supposed '84:16' dichotomy

According to the White Paper, 'South Africa spends 8.5% of GDP on health. [Of this] 4.1% of GDP is spent on 84% of the population, the majority utilising the public health sector, whilst 4.4 % of GDP is spent on only 16% of the population in 2015/16'. [Para 92, White Paper]

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

The proportion of people treated in the private sector thus varies between 28% and 38%, leaving between 72% and 62% to seek treatment from the state. In addition, current figures on public/private utilisation show that 37% of people use private GPs, that 38% rely on private nurses, that 28.5% go to private hospitals, and that 59% use private specialists. [Serfontein, FMF presentation, 20 April 2016] (The figures on the use of private specialists reflect the fact that 59% of specialists work in the private sector. This in turn is largely the result of the government's emphasis on primary care, as well as the various other factors, including poor management, that drive specialists out of public health care facilities.)

The White Paper also seems to suggest that the private sector is 'not doing its share' in meeting the health needs of the country. In fact, the private sector pays the great bulk of all health care costs in South Africa. The roughly R178bn spent on private health care in 2015/16, amounting to some 50% of total health care expenditure, comes mostly from private firms and individuals and their contributions to medical schemes, medical insurance, and out-of-pocket fees. The roughly R173bn budgeted for public health care expenditure in 2015/16 comes from tax revenues, the bulk of which is paid by private firms and individuals. In addition, the tax system is extremely progressive, for the wealthiest quintile contributes some 82% of total health care financing and receives 36% of the benefits. [Para 259, Table 2, White Paper; 2016 *Survey*, p561; Dr Chris Archer, NHI Commentary, Presentation to the Free Market Foundation, 20 April 2016]

National and provincial spending on public health care has also risen dramatically since 1994. Though this partially reflects the impact of inflation, the steep increase also shows the great effort being made to expand access to public health care. Hence, in 1994/5, spending on public health care amounted to R15.6bn, whereas in 2015/16 it came in at roughly R157bn. In addition, the proportion of total health care expenditure going to the public sector, rather than the private system, has steadily increased. Hence, whereas in 1994/95 some 60% of total spending was in the private system and 40% in the public one, by 2013/14 only 52% of total spending was in the private sphere and the balance in the public system. Moreover, total spending on health care as a proportion of GDP has risen significantly, from 7.4% in 1995 to 8.9% in 2013. [2016 *Survey*, pp560, 561]

Increased spending on public health care helps explain the progress South Africa has in fact made in countering its heavy burden of disease. This is unusually high compared to other countries because of the HIV/AIDS pandemic, a concomitant growth in related diseases, such as tuberculosis (TB), a steady increase in non-communicable diseases, often resulting from

obesity and lifestyle issues, and a very high incidence of injuries from car accidents, assaults, rapes, and attempted murders.

The country now has close on 3 200 public clinics, many of them built since 1994. It now has close on 410 public hospitals, providing more than 85 300 beds. (By contrast, there are roughly 200 private hospitals, with some 31 000 beds.) Vaccination and immunisation rates have risen from 67% in 2001 to 90% in 2014. The country has achieved a huge roll-out of antiretroviral medicines (ARVs), which now reach more than 2.1 million people living with HIV/AIDS. Thanks to this ARV roll-out, deaths from AIDS have been substantially reduced in recent years, while life expectancy has risen from 54 years in 2005 to 58 years in 2015 [2016 *Survey*, pp581, 583, 586, 694]

Driven largely by the AIDS pandemic, TB infection has risen sharply, prevalence rates rising from 475 per 100 000 people in 1990 to 715 per 100 000 in 2013. But the death rate from TB among people without HIV co-infection has remained much the same: at 42 per 100 000 in 1990, compared to 48 per 100 000 in 2013. Malaria cases and deaths are very sharply down, from some 27 000 cases and 163 deaths in 1996 to roughly 3 800 cases and 100 deaths in 2013. Important progress has also been made in reducing severe malnutrition and the incidence of diarrhoea among under-fives. [2016 *Survey*, pp597-600] Infant and maternal mortality rates remain unacceptably high, but this is largely because of avoidable failures in the public health care system (see *Avoidable deaths*, below).

High costs in the private sector

The White Paper assumes that private healthcare costs are inordinately high and that the NHI system is needed to reduce them. It states, among other things, that 'medical scheme members are not well protected from the escalating costs of health care'; and that the private sector is characterised by:

(a) 'exorbitant costs due largely to a fee-for-service model';
(b) an 'imbalance in tariff negotiations between purchasers and providers'; and
(c) 'small and fragmented risk pools in each medical scheme, where there is limited cross subsidy between the young and old, the sick and healthy,…the rich and the poor'. [Para 67, White Paper]

The White Paper adds that medical schemes, over the past decade, have been 'increasing member contributions at levels that are higher than CPI [the consumer price index], whilst the health benefits of members have been reducing significantly'. [Para 69, White Paper] It also says that 'private hospital prices in South Africa are expensive relative to the country's wealth and they continuously raise rates above inflation'. Private hospitals, it claims, are also 'least affordable when compared to OECD countries, even for individuals at higher levels of income'. [Para 69, White Paper]

However, there is little factual foundation for these accusations. Nor is there a sound basis to the health minister's repeated accusations that private hospitals charge fees that are absurdly high, compared to those in public hospitals. In 2012, for instance, Dr Aaron Motsoaledi stated

that a private hospital charged R150 000 for a spinal decompression, whereas the Steve Biko Academic Hospital in Pretoria charged only R30 000. In addition, he said, private hospitals charged R15 000 for circumcisions, whereas township clinics charged 'only a few rand'. But Garth Zietsman, a statistician, disputed the comparisons cited and said they were 'probably chosen to be maximally misleading'. [*Mail & Guardian* 11 May 2012]

According to Mr Zietsman, the minister had failed to mention the huge state subsidy, paid by taxpayers, that financed public health. He had also failed to acknowledge that there could be differences in the conditions involved: most circumcisions were straightforward, but some were not. Spinal decompression could be done in different ways, depending on particular needs, and some were more complex than others. On a more appropriate comparison, added Mr Zietsman, private hospital costs were on average only 1.4 times more expensive that public hospital costs. If all relevant factors were taken into account and like was more strictly equated with like, then private hospital costs were a mere 1.1 times those of public hospitals. [*Mail & Guardian* 11 May 2012]

In addition, many of the problems identified in the White Paper stem largely from the government's own regulations on medical schemes (see *Limited membership of medical schemes*, below). Other regulatory constraints have also added significantly to private sector costs, which could thus be reduced by appropriate policy reforms.

Dr Motsoaledi has also blamed high private health costs on the dominance of three listed hospital groups in South Africa. According to the minister, the main culprits are MediClinic, Netcare, and Life Healthcare, which together control more than 70% of the local private hospital market. 'Greedy specialist doctors' are also to blame, the minister adds, saying: 'Profit-maximising specialists and hospitals are able to exert their dominance through price increases and price discrimination with relative impunity, and currently have no need to compete on either price or quality in order to attract patients.' [*Financial Mail* 12 February 2015]

At the urging of Dr Motsoaledi, the Competition Commission is currently investigating high prices in private health care and the reasons for them. Its Health Market Inquiry is now expected to complete oral hearings in May 2016 and will be finalised by the end of the year. (Pressure for the health minister for such an inquiry goes back to 2010, soon after his appointment by the first Zuma administration, when Dr Motsoaledi said he wanted 'an independent commission to regulate prices in the private healthcare sector'.) [*The New Age* 23 November 2015, *Business Day* 19 May 2010]

However, in documents submitted to the commission's inquiry, the three hospital groups and other commentators have disputed the health minister's assessment. The main cost drivers lie rather, they say, in increased utilisation of private hospitals, a rising number of people with medical scheme membership or other hospital insurance, a growing burden of disease, an ageing population, the introduction of new medicines and medical technologies, increased labour costs, especially for nurses (as the private sector has had to push up salaries to

compete with rapid wage increases in the public service), steep increases in electricity and other administered prices, the declining value of the rand, and significant increases in the overall consumer price index which add to food and other input costs. Increased litigation against doctors is also a factor, says Chris Archer of the South African Private Practitioners' Forum. 'Doctors practise defensive medicine to protect against possible litigation. This makes at times for unnecessary investigations and even procedures'. [*Business Day* 23 September, *The Times* 6 February, *The Citizen* 19 February, *The Times* 19 August 2015]

In addition, medical inflation is inevitably higher than general consumer inflation, not only in South Africa but also elsewhere in the world. In fact, prices for health care in South Africa have risen more slowly than in other countries: by 4% from 2009 to 2012, compared to a global average of 6.2%. In addition, in 2011, for example, health care inflation stood at some 8.4% in the United States of America (USA) and Canada, at 8% in the United Arab Emirates (UAE), at 7.8% in Malaysia, and at 5.8% in Mexico. It also exceeded 5% in Brazil, France, the UK, and Singapore, and came in at more than 4% in Italy, China, Chile and Russia. South Africa's rate, by contrast, was then 3%. Overall, South Africa had the 8th lowest net health care cost inflation out of 52 countries surveyed. Only India, the Philippines, Cyprus, Romania, Ukraine, and Egypt had lower levels. [Business Day 23 September 2015; Archer, FMF presentation, 20 April 2016]

The three hospital groups also deny having the level of market power claimed by the minister. They point out that close on 80% of medical scheme beneficiaries are represented by three large medical schemes: Discovery Health, with a market share of 32%, Metropolitan Momentum International, with a market share of 35%, and Medscheme, with a market share of around 12%. The private hospital sector has to negotiate tariffs with these (and other) medical schemes, which have major negotiating power and (says Netcare) can 'largely determine the outcome of the negotiating process'. This 'acts as a significant constraint on private hospital operators'. The National Hospital Network, an association of independent hospitals not forming part of the big three, agrees with this assessment. [*Financial Mail*, 12 February 2015]

Also relevant here is the Competition Commission's ruling in 2004, which scrapped collective bargaining between medical schemes and service providers as anti-competitive. The commission took the view that, without such collective bargaining, patients would be able to negotiate with their doctors for lower fees. In practice, however, this has proved impossible. If medical schemes were again permitted, as a group, to negotiate prices, it would give them greater bargaining power to secure more favourable prices from health care providers and then pass these savings on to consumers through reduced premiums. [*Business Day* 22 October 2010, 30 July 2015]

At the same time, says the South African Private Practitioners Forum, specialist fees are often not as high as is commonly assumed. Though some specialists may charge around 300% of medical aid rates, many do not. For example, 'over 80% of practices in the specialist disciplines of physical medicine, psychiatry, radiotherapy, cardiology, and oncology charge

no more than 120% of medical scheme rates'. The specialists with the highest overheads and unavoidable malpractice premiums are plastic surgeons, orthopaedic surgeons, and gynaecologists, but even here roughly half or more charge between 100% and 120% of medical scheme rates. (Some 45% of plastic surgeons charge within this band, as do 54% of orthopaedic surgeons and 60% of gynaecologists). In addition, the country suffers from a chronic shortage of specialists, which could be overcome if private training facilities were allowed. [*The Star* 16 March 2015, *City Press* 13 March 2016]

Often, moreover, it is government's own regulations that make it harder to bring down costs. The state's restrictions on the building of new private hospitals and clinics limit new entrants and reduce competition. By contrast, more hospital beds would increase competition and lower costs for patients. Hence, subject to regulations regarding patient safety, the private sector should be allowed, indeed encouraged, to open as many hospitals, clinics, and day medical centres as it wishes. It should also be able to purchase whatever medical equipment it considers necessary or useful, without first having to obtain state permission.

Also relevant here is the state's prohibition on private hospitals employing doctors and specialists. This means that these medical practitioners have to fund their own consulting rooms and equipment and bill their patients themselves. By contrast, there would be savings if hospitals could employ them and provide them with all the facilities they need, while also benefiting from resulting economies of scale. [*The Times* 19 August 2015]

In many ways, thus, the government's own rules serve to push up prices in the private sector by constraining the training of doctors and nurses, the expansion of medical facilities, the purchasing of medical equipment, the hiring of doctors, and the negotiation of price discounts for bulk orders of medicines (which is barred by the government's insistence on a 'single exit price' for all purchasers other than itself). [Anthea Jeffery, *Chasing the Rainbow: South Africa's Move from Mandela to Zuma*, IRR, 2010, p76] There are also many regulatory obstacles to bringing down the cost of medical scheme membership, as further described below.

Also relevant is the time (often five years) it takes to register a generic medicine through the Medicines Control Council. This creates a huge backlog in the availability of cheaper medicines. As a result, only around 50% of the medicines prescribed by South African doctors are generic, which is much lower than the 70% in the United Kingdom (UK) and the US. [*The Times* 9 February 2015]

It is also the deteriorating infrastructure and poor service in public clinics and hospitals that push people towards the private sector. [*The Times* 9 February 2015] This increases the demand for private health care, even as government regulations make it more difficult for the private sector to meet this higher demand. If the government wants more competition to help drive down prices in the private sector, it has a key remedy readily available to it. All it need do is improve the quality of public health care, for this in itself would remove the imperative that many people now feel to seek private care instead.

Limited membership of medical schemes

As earlier noted, the White Paper complains that medical scheme membership is too limited (reaching only 16% of South Africans); that medical scheme fees are rising too quickly; that medical scheme benefits are too limited and often run out; and that medical scheme members often have to make substantial co-payments for private medical services. [Paras 92, 66, 67, 69, White Paper]

The number of people belonging to medical schemes has risen from 6.9 million in 1997 to 8.8m in 2014. [2016 *Survey*, p563] However, because the population has also increased over this period, medical scheme membership as a proportion of total population has remained much the same, at 17% in 1997 and 17% in 2016. However, the demographic representation of medical schemes members has changed over the years, for 50% of members are now black, 10% are coloured or Indian, and the remaining 40% are white. [Archer, FMF presentation, 20 April 2016] However, it is the government's policies that have made it more difficult for medical schemes to enroll more members at affordable prices.

Among these policies are regulations requiring medical schemes to maintain reserves at 25% of contributions received. This percentage seems to have been arbitrarily chosen, for there is no scientific or actuarial foundation for it. It does, however, make it more difficult for new schemes to establish themselves. It also ring-fences an unnecessarily high proportion of premium income, leaving less available to pay for medical services. According to Jonathan Broomberg, chief executive of Discovery Health, South Africa's largest private medical scheme, 'medical schemes are currently sitting on R10bn in excess capital and reforms to the solvency requirements would immediately assist with affordability of premiums'. [*The Times* 9 February 2015, *Business Day* 1 February 2016]

Another factor contributing to higher costs is a 2004 ruling by the Competition Commission, as earlier noted, which barred negotiations between medical schemes and health practitioners on a suitable tariff of fees for medical services. The commission said such negotiations amounted to anti-competitive price collusion and could not be permitted. [*Business Day* 30 July 2015] Since then, the prices charged by specialists, in particular, have risen significantly (though often not as much as is commonly assumed). At the same time, the number of young and healthy people signing up for medical schemes has declined, partly because premiums are so high. But the young and healthy group is needed to help cross-subsidise the old and sick members of a medical aid scheme and so keep the scheme afloat.

Medical schemes have responded by setting their own caps on how much they will pay for consultations and procedures. However, many doctors and specialists charge more than these capped amounts, which means that members have to cover the shortfall themselves via 'co-payments'. In 2014 members were compelled to pay R20.7 billion in addition to their premiums to cover shortfalls on what their medical schemes paid out. According to Humphrey Zokufa, chief executive of the Board of Healthcare Funders (BHF), which represents some 65% of medical schemes in the country, these out-of-pocket payments are a

source of much unhappiness among members and are prompting a further exodus from medical schemes. [*Business Day* 13 July 2012, *City Press* 25 October 2015]

Open enrolment and community rating, without compensatory regulations
Also relevant are rules requiring 'open' enrolment and 'community' or non risk-rated premiums. These regulations mean that no prospective member may be turned away, irrespective of age or illness, or made to pay a higher premium (though limited 'late-joiner' penalties and waiting periods for existing conditions are allowed). This means that the young and healthy have less reason to join medical schemes, which end up with a disproportionately large percentage of older and sicker members whose health needs are greater and more costly to fulfil. [*The Times* 6 February 2015]

These rules were supposed to be offset by compulsory medical scheme membership for all South Africans in formal employment, which would have compelled the young and healthy to join and helped reduce premiums for all. This requirement was supposed to have been supplemented by the establishment of a 'risk equalisation fund', under which schemes with higher number of younger members would have cross-subsidised schemes with higher numbers of older members. However, these additional promised interventions have not been made. Hence, most medical schemes have too many 'high-cost' members, which pushes up average premiums for everyone. [*The Times* 6 February 2015]

Also relevant are further provisions in the Medical Schemes Act of 1998, which ensure that most medical aid benefits are reserved for hospital treatment. This leaves less funding available for preventive treatments or for health care provided outside of hospitals. [*The Times* 9 February 2015]

Full payment for some 300 prescribed minimum benefits (PMBs)
Particularly significant are rules (in section 29 of the Medical Schemes Act and its accompanying regulation 8) which require all medical schemes to provide all their members, irrespective of the premiums they pay, with 'prescribed minimum benefits' (PMBs) for a host of specified conditions. Included on the PMB list are 270 medical conditions, such as cancer and pneumonia, along with 25 chronic conditions and emergency care. According to Regulation 8, moreover, medical schemes must 'pay in full' for the treatment of illnesses covered by PMBs. Every medical scheme member, irrespective of the cover they have signed on to receive, is entitled to these PMBs. This in turn means that medical schemes cannot offer membership at less than R600 per person per month, which is the minimum amount needed to cater for the likely cost of the PMBs. This pushes up medical scheme premiums for everyone. [*The Times* 6 March 2015]

When PMBs were introduced, the legislation suggested that medical schemes were required to pay for PMBs only if the services were provided at a state hospital. Writes journalist Bronwyn Nortje in *Business Day*: 'The result was that patients who had previously been treated at private hospitals under medical aid had to seek treatment at public hospitals which were quickly overwhelmed. The result was a skirmish between the medical schemes, their

members and the Council for Medical Schemes (a statutory body charged with regulating the medical schemes industry) over who should foot the bill. After some discussion and a court case, the registrar of medical schemes issued a circular stating that the provision of PMBs by a scheme is obligatory regardless of where the service is received. This was all well and good for the state hospitals, but was the beginning of a lengthy tale of woe for medical schemes, which found themselves responsible for all costs – no matter how high – related to the treatment of PMB conditions. [This] open-ended liability caused havoc on their balance sheets. Apart from costing a lot more and making their risk more difficult to model, the legislation also created a perverse incentive for some providers to charge far higher rates to treat PMB conditions... These higher medical costs have simply translated into higher premiums. These higher premiums have in turn resulted in some people being forced to leave the schemes because they are unable to afford them. This has ultimately reduced medical scheme coverage.' [*Business Day* 23 July 2015]

Some medical schemes have responded by arguing that Regulation 8 requires them to pay their own normal medical aid tariffs 'in full', but does not oblige them to cover the higher amounts that doctors or specialists may in fact charge. Some also argue that they are entitled to reduce their liability for PMBs by setting out limits in the rules of their schemes. However, in November 2015, the Supreme Court of Appeal rejected this second argument. [*Business Day* 18 November 2015]

This case arose when Genesis medical scheme refused to pay for three external prostheses provided by a private hospital in treating a member with a broken leg, which is a PMB condition. Genesis argued that its rules covered prostheses only if these were fitted at state hospitals. But Judge Eric Leach ruled that Genesis could not contract out of the obligations set out in the Act, which required it to pay in full for PMBs. Judge Leach said that the relevant legal provisions were 'clearly designed to ensure that members would not be obliged to bear the cost of providing treatment' for PMBs. In addition, the minister of health had clearly intended that members should be covered for PMBs whether they were treated in private or state hospitals. This objective would be defeated if a medical scheme provided cover only if the treatment was obtained from the public sector, thereby effectively shifting the cost of treating PMBs on to the state. Instead, the Act provided Genesis with the opportunity to manage its liabilities for PMB payments by appointing private doctors and hospitals as its designated service providers, but it had failed to do so. Hence, it was obliged to pay for the prostheses in full. [*Business Day* 18, *Saturday Star* 21 November 2015]

Genesis said it would appeal the ruling to the Constitutional Court. If the judgment was allowed to stand, it would in practice oblige medical schemes to increase their premiums substantially to cover the full costs of private treatment for PMBs. This in turn would mean that non-PMB benefits would be eroded – and that membership of medical schemes would become increasingly unaffordable for most people. [*Saturday Star* 21 November 2015]

In July 2015, however, Dr Motsoaledi tabled a draft amendment to Regulation 8, under which medical schemes would be able to limit their PMB payments to doctors and specialists to the

fees set out in a 2006 tariff guide, called the National Health Reference Price List. (This is the most recent valid set of tariffs published by the Council for Medical Schemes, as a 2009 equivalent was struck down by the Pretoria high court in 2010, see below.) The 2006 figures would be adjusted by the consumer price inflation rate, but would still be significantly below what many doctors and other service providers were charging for PMBs. Cosatu hailed this as a major victory, as it would force all doctors and specialists to subscribe to a regulated tariff for PMBs, while medical schemes would still be obliged to provide full treatment for all PMBs, without any limits or co-payments for members. [*Saturday Star* 18 July, *Business Day* 23 July 2015]

However, a number of doctors responded that the proposal was unfair, as the 2006 reference list had no scientific basis and took no account of the actual costs of providing a service. In addition, medical inflation (for all the reasons earlier outlined) had far exceeded consumer inflation since 2006, making the maximum permitted fees all the more inadequate. Moreover, the North Gauteng High Court, back in 2010, had already declared an equivalent 2009 reference price list null and void as 'irrational and unreasonable' as it would make it difficult for 'private practitioners to cover their costs, let alone make a reasonable return on investment'. At the same time, the Treatment Action Campaign (TAC) argued that the revised rules could result in increased co-payments for patients, which could bring financial ruin to households forced to share the costs of PMBs. [*Business Day* 29 July 2010, *Saturday Star* 18 July, *Business Day* 23, 28 July 2015; Archer, FMF presentation, 20 April 2016]

In the face of these conflicting perspectives, the minister has left the matter unresolved. The requirement that all medical schemes must 'pay in full' for PMBs thus continues to price medical aid coverage beyond the reach of many households. Again, this is a matter easily within the power of the state to rectify.

Low-cost medical schemes still barred

In September 2015 the Council for Medical Schemes responded to the affordability problem by approving an exemption framework to the Medical Schemes Act that would allow medical schemes to offer people low-cost options. The council said these options would expand the medical scheme market and draw as many as 15 million more people into membership of medical aids. [*Business Day* 29 July,15 October 2015, *Saturday Star* 1 August 2015]

These low-cost options were scheduled for introduction from January 2016 and were expected to have premiums as low as R180 a month for an adult member. Costs would be kept down by exempting them from having to cover all PMBs, while members would be required to use state hospitals rather than private ones. However, the schemes would also provide a mandatory minimum package of services, including five consultations a year with a private general practitioner (GP), access to a pre- and post-natal programme, routine health screenings, and the provision of chronic and acute medicines. This in itself would spare millions of people from having to spend hours or days waiting for such services at state facilities, so generating broad economic and health benefits for the nation. Moreover, to prevent existing medical scheme members from 'buying down', the low-cost options would

be available solely to people earning below the personal income tax threshold, then R70 700 a year (roughly R6 000 a month) for people below the age of 65. Membership might also be confined to employer groups, as all the employees of the relevant employers would then have to join, helping to bring about a cross-subsidisation from younger to older members). [*Business Day* 29 July,15 October 2015, *Saturday Star* 1 August 2015]

A month later, however, the council announced that it was suspending the introduction of these low-cost options until further notice. The announcement came two days after a meeting of the ANC's national general council (NGC), which had called for the urgent introduction of the NHI. This raised questions as to whether political interference had played a role in the council's sudden about-turn. Wrote Bronwyn Nortje in *Business Day*: 'Two industry sources mentioned that the council received a call from the Department of Health following the NGC meeting, telling it to withdraw the low-cost benefit options immediately as they were considered a stumbling block on the path to the NHI.' Dr Motsoaledi denied this, saying that the low-cost options were 'an insult to low-income earners' and would not provide 'an acceptable level of care to members'. [*Business Day* 15, 16 October 2015] But the NHI scheme, with its high costs and inadequate benefits, would also be much more difficult to justify if low-cost options had already been made available to low-income households.

Pending restrictions on medical insurance

Another low-cost option, which is already in operation, is now under threat from the state. Hundreds of thousands of low-income individuals have responded to the growing cost of medical aid by taking out health insurance covering them for the costs of hospitalisation and providing them with primary health care benefits. These combination insurance products are not subject to medical scheme rules, which means they can differentiate on the basis of age and health. Insurance products are thus particularly attractive to younger and healthier people – the very market that medical schemes want to cross-subsidise their older and sicker members. [*Saturday Star* 5 September 2015]

The National Treasury is thus seeking to ban insurers from offering primary healthcare plans, on the basis that these involve the business of a medical scheme. Such a ban will, of course, help to sustain the medical aid industry, as will further proposed bans on insurance companies providing hospital cash plans and 'gap' cover to fund the difference between medical aid rates for doctors and specialists and what these practitioners in fact charge. However, these prohibitions will also harm some 800 000 South Africans who cannot afford to join a medical scheme under the costly requirements imposed by the state – but stand to lose their insurance cover if these further controls are introduced. [*Business Day* 29 July, 9 September, *Saturday Star* 5, 12 September 2015]

The high price of the government's regulations

Without the government's regulatory interventions, low-cost medical schemes would already be available to low-income households, along with low-cost insurance products that would also give them access to private hospitals. The full cover for all PMBs that the government insists upon also goes beyond what most people desire or require. It is the state's

determination to impose this form of 'social solidarity' that is driving lower-income and healthy people out of the medical scheme market. It also means that the risk pool of people with medical scheme membership is becoming smaller and less healthy. This in turn is driving up the premiums required and making medical schemes increasingly unaffordable. This, in turn, has generated a vicious cycle in which the medical schemes industry is under ever more financial pressure.

The government is now using this situation to warn that medical schemes could soon go out of business – and that the solution lies solely in the introduction of the NHI system. This is a classic example of the state imposing so much damaging regulation that the market can no longer function – and then claiming that the only solution to this supposed market 'failure' is yet more intervention and (in the case of the NHI) an end to private provision altogether.

An end to private health care is not, however, what most South Africans want. This is evident, for example, from Statistics South Africa's 2014 household survey, which found that 29% of respondents turned first to private sector practitioners, private clinics, and private hospitals when household members were ill. [*Financial Mail* 9 September 2015] Many more people would doubtless do the same if they could afford this, rather than having to rely on the inefficient and poorly managed public health care system.

Poor standards in public health care

The White Paper acknowledges that there are 'quality problems' in the public health service, in areas such as 'staff attitudes, waiting times, cleanliness, drug stock-outs, infection control, and security' for patients and practitioners. It notes that 'increases in utilisation', resulting mainly from the high burden of disease and increased patient loads' have added to the pressures on the system. As earlier noted, it then goes on to blame the shortcomings in public health care on 'the existence of a two-tier healthcare system where the rich pool their health care funds and resources separately from the poor'. [Paras 75, 77, White Paper] But this assessment is rooted in an ideological hostility to the private sector, rather than in reality. It turns a blind eye to the true reasons for the evident problems, and once again ignores the government's own role in exacerbating these.

Factors pushing practitioners out

Some of the factors pushing health care professionals out of the public system can be traced back to the late 1990s, when the Government announced a (supposedly) new focus on primary health care. This was in keeping with the *Declaration of Alma Alta* adopted by the World Health Organisation (WHO) in 1978, which had emphasised the importance of providing easy access to a relatively low level of health care, while also preventing the spread of disease through improved sanitation, access to clean water, and immunisation. Resources were thus re-allocated from the tertiary sector to the primary one, so as to provide a number of new clinics in under-serviced areas. By 2007 the number of clinics had risen to some 1 600, while headcount visits had increased from some 67 million in 1996/97 to almost 102 million in 2006/07. However, the benefit to the poor was questionable, for a large proportion of the new clinics (60% in 2004) had no properly trained nurses and few had adequate

medicines in stock. [Jeffery, *Chasing the Rainbow*, p343]

At the same time, increased revenue for primary health care came at the expense of the country's top teaching hospitals. The government severely cut the budgets of the best state hospitals, while criticising them for their supposed preoccupation with heart transplants and other 'diseases of the rich'. In many instances, state hospitals (such as Groote Schuur in Cape Town, where the world's first heart transplant had been carried out) were instructed not to carry out such operations any more. This ignored the extent to which Groote Schuur and other tertiary hospitals had long been engaged in helping the poor. It also encouraged an exodus among doctors concerned that the government had little regard, as R W Johnson writes in his book *South Africa's Brave New World*, 'for the things which had made South African medicine so distinguished in the past'. Some health professionals spoke of the need for 'a more careful balancing act' between primary and tertiary health, but Professor Solly Benatar, a scholar of South Africa's health services, was more blunt. Professor Benatar warned that the attrition of tertiary services in favour of primary services which were often dysfunctional meant 'greater losses than gains in health care in the short term and adverse implications for the future'. [R W Johnson, *South Africa's Brave New World: The Beloved Country Since the End of Apartheid*, Allen Lane, London, 2009, p463; Jeffery, *Chasing the Rainbow*, p343]

President Thabo Mbeki's irrational response to the growing HIV/AIDS pandemic and reluctance to allow the use of ARVs further damaged the public health care sector. It hugely compounded the burden of disease and generated among many doctors in state hospitals a 'feeling of hopelessness, major hopelessness' as to how to cope with these new challenges. It also fuelled a major exodus of doctors and nurses out of the public health care and into private health care or abroad. This added to the pressure on remaining health personnel while demoralising them even further. [Jeffery, *Chasing the Rainbow*, p345]

By 2002 some 5 000 South African doctors and another 18 000 health professionals were working abroad. The *South African Health Review* warned that the Government 'could forget about a functioning health system' unless this were reversed. In the same year, 29 000 posts in the public health system were vacant. By 2008 the number of vacant posts for doctors and nurses in public hospitals had risen to close on 38 000. Commented *Business Day* in an editorial: 'That's a huge hole, no matter how you look at it. It's the reason patients queue for hours to get their medicines, babies die from in-hospital infections, and those who can afford it now seek care in the private sector. Highly skilled and dedicated staff are leaving because the pay is terrible [and] the working conditions foul.' [Jeffery, *Chasing the Rainbow*, p347] Since then, little has been done to overcome this situation.

Poor management

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

hold managers accountable. [John Kane-Berman, From *Last Grave at Dimbaza* to three tiny graves at Bloemhof, IRR, *@Liberty*, 10/2014, 24 June 2014, p2]

In 2009 a special series of the *Lancet* (a renowned medical journal published in London, New York and Beijing) focused on South Africa and spelt out in painful detail the negative consequences of poor management in the public health care sector. Wrote the *Lancet* report: 'Poor leadership and stewardship (taking responsibility) run like a ruinous cancer through the public health care system. Post 1994, many inexperienced managers were placed in positions of seniority and they have struggled to deal with major challenges, particularly human resource management. Incompetence within the public sector is widespread and the government has lacked the political will…to manage underperformance in the public sector. Loyalty rather than ability to deliver has been rewarded. Leaders and managers have not been held accountable when mistakes have been made. Without concerted efforts to change national thinking on accountability, South Africa will become a country that is not just a product of its past but one that is continually unable to address the health problems of the present or to prepare for the future.' [*The Star* 25 August 2009]

In 2011 a competency report conducted by the Development Bank of Southern Africa found that 'teachers, nurses, and even clerks whose highest qualification was a matric certificate were running [major] hospitals'. The study was commissioned by Dr Motsoaledi, who 'promised to fix the management crisis in hospitals, including removing under-qualified and poorly performing CEOs and delegating more powers to management to perform elementary but essential functions'. He said unqualified chief executives had been appointed through 'a combination of bad policy and political patronage'. The policy mistake was to think that because public hospitals were now supposed to be run 'on business principles', their chief executives no longer needed a clinical background. This policy had also been abused to allow 'a free-for-all'. [*Financial Mail* 10 June 2011]

While some hospitals had well-educated chief executives, the minister went on, 'they did not have the right competencies to manage a hospital'. In some of the most extreme cases, people who were previously only at level 8 of the public service – a junior rank where remuneration ranges from R174 000 to R205 000 a year – were appointed to run hospitals. 'In the Northern Cape, most CEOs were nurses, in Limpopo there were a lot of teachers. The criteria provincial departments followed were curious', added Dr Motsoaledi. However, as the minister acknowledged, ridding the system of unqualified managers would not be easy and could certainly not be attempted 'en masse'. [*Financial Mail* 10 June 2011]

In September 2012 *The Star* reported on a growing crisis in public health care in Gauteng. The general consensus among a number of health workers, activists, and government officials (who declined to be named) was that 'the crisis was the result of years of poor administrative and financial mismanagement, overseen by the provincial department and politicians'. The province's health woes have been building up for well over five years, 'with constant overspending, spending on unfunded mandates, and the awarding of lucrative tenders to government allies who then failed to deliver'. Forensic audits pointing to corruption had

generally not been followed up, though R1 billion's worth of tender fraud was now under investigation by the Hawks (a specialist unit within the police, intended to combat corruption and organised crime). The critical challenges facing public health care in Gauteng thus included: [*The Star* 7 September 2012]

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

A former minister of science and technology, Mosibudi Mangena, added that the problems in the public health care system were the result of 'political appointments and incompetence. Said Mr Mangena: 'Until we insist on the appointment of suitably qualified and competent people to manage health affairs and to hold those we appoint accountable, our hospitals will continue to be death traps.' Ours is a 'murderous health system', he went on. 'We read, see, and hear, almost daily, about the needless deaths of our people in our hospitals, babies dying in their mothers' wombs, babies being needlessly brain-damaged during childbirth, the lack of linen and food in our facilities, our filthy hospitals.' [*The Citizen* 28 February 2012]

Poor conditions persist

Little improvement has been brought about since then. In February 2015, for instance, a number of doctors working in Free State (who chose to remain anonymous for fear of victimisation) wrote to the provincial MEC for health, Benny Malakoane, and the provincial premier, Ace Magashule, to describe how the provincial health care system was being destroyed. Not many years ago, the doctors wrote, hospitals in the Free State were 'among the best in the country', providing excellent medical care and training for medical students and specialists. Now many hospitals were in a state of disrepair. Elevators regularly broke down, which meant that hospital staff had to carry patients up and down stairs on stretchers. People in intensive care, who could not be transported in this way, 'simply could not be operated upon, so unnecessary deaths occurred'. ['How the Free State health system is being destroyed', Ground-Up, 27 February 2015]

If renovations to hospital buildings were attempted, they were 'often halted midway without any explanation offered'. Moreover, the work that was carried out was 'usually amateurish and sub-standard'. Broken windows were not repaired, but rather covered over with plastic or cardboard. Moreover, while hospitals were neglected, scarce resources were lavished on posh offices for provincial officials. [Ibid, p2]

Worse still, there was 'a constant shortage of the most basic medicines and consumables'. Even the most basic and inexpensive antibiotics were often out of stock. Patients and their

families had to provide their own consumables, including wound dressings and basic medicines. Said the doctors: 'Excuses vary from unavailability of stock from the suppliers to ineptitude in the medical depot. Often the suppliers do not deliver stock because they are not being paid by the government.... No one appears to take responsibility and no one is held accountable.' In addition, equipment was often old and outdated. It was seldom serviced and 'almost never replaced when broken'. [Ibid, p2]

At the same time, doctors who qualified for promotions and pay increases were denied these because of a lack of funds, but were nevertheless expected to take on ever more responsibilities. There were too few ambulances, while 70% of ambulance personnel were inadequately trained and could not provide necessary emergency care. X-ray services were generally not available at night. By contrast, additional and unnecessary management posts were created, even as vacancies for doctors and specialist posts remained unfilled. Commented the doctors: 'Patients lie for weeks and even months awaiting surgery due to lack of equipment or specialists.' [Ibid, pp2, 3, 5]

The situation, they went on, was particularly bad at the Universitas Academic Hospital in Bloemfontein, the main tertiary care hospital in the Free State and a key training facility for medical students and specialists. Much of the deterioration had followed the appointment of Dr Sehularo Gaelejwe as the hospital's chief executive, they said. Added the doctors: 'Staff who differed from him or had the slightest whiff of misconduct hanging over their heads were suspended'. One specialist was given a final written warning for having drawn up a call list in Afrikaans as well as English. After one of his patients died (because Dr Gaelejwe's unwarranted interventions had brought about the closure of the cardiology department), he resigned. Overall, about 20 specialists resigned, while a significant number of others threatened to do the same if Dr Gaelejwe remained chief executive. Though he was then quietly removed, so much damage had by then been done that the Universitas Hospital might never recover. [Ibid, p4]

Added the doctors: '[The situation is similar] at the Dihlabeng Regional Hospital in Bethlehem, where a total of four medical officers remained in March 2015, down from 20 in 2012. At the moment only emergency procedures are performed and many patients awaiting surgery are turned away. Many hospitals teeter on the brink of collapse, barely managing on minimal doctors and nursing staff... Most doctors and nurses try their best to keep Free State hospitals afloat under these tough circumstances, but they receive no support from the Department of Health. Instead, they are blamed for most problems.' [Ibid, p5]

In November 2015 the Treatment Action Campaign (TAC) released the findings of a 'People's Commission of Inquiry' it had established to probe the Free State health care system. The report painted a bleak picture of a system in crisis. It highlighted problems in virtually every aspect of the provincial system, from inadequate emergency services to life-threatening shortages of medicines. The provincial health department, having declined to take part in the investigation, dismissed the report as inaccurate, saying it relied on 'old, false information that was not procedurally acquired and was thus devoid of truth and context'.

However, the provincial department is also facing 184 claims, amounting to R700m, for incidents of alleged medical negligence dating back to 2004. In the past three years, it has also paid out R18m for claims of this kind. [*Business Day* 11 November, *The New Age* 20 May 2015]

In March 2015 an oversight tour of nine major hospitals by the Democratic Alliance (DA) found 'catastrophic' conditions at most of these institutions. Problems identified by the DA included severe shortages of doctors and other health personnel, 'a chronic shortage' of medicines, an increase in secondary infections within hospitals, a failure to deal properly with medical waste, a shortage of beds, and a failure to maintain generators in working order to counter repeated 'load-shedding' or electricity blackouts. [Wilmot James, South Africa's horrible hospitals, Politicsweb.co.za, 23 March 2015]

Worsening stock-outs of medicines

In 2012 an audit of public health care facilities (see below) found that average compliance scores were 54% on the availability of medicines and supplies. A one-time head of a trauma unit said the government hospitals often ran out of such essentials as pain-killing drugs. 'One day we run out of Panado, so we have to use morphine even on small babies. The next day there will be no morphine, so we have to use Panado.' In 2013 a group of non-governmental organisations in the health field reported that 20% of more than 2 000 facilities surveyed ran out of ARVs and TB medication. [Kane-Berman, From *Last Grave at Dimbaza*, p4]

Since then, complaints about medicine stock-outs have increased rather than declined. In May 2015 *The Times* reported that 'the current list of medicines that are out of stock or in short supply around the country runs to six pages'. It includes antibiotics, TB medicines, ARVs for adults and children, and drugs to treat high blood pressure, anxiety, epilepsy, fungal infections, and pain. A civil society organisation, The Stop Stock-outs Project, added that shortages were assuming 'crisis proportions'. The deficits were also increasing the risk of drug resistance developing among patients, which could make it even more difficult to counter the massive HIV/AIDS pandemic. In addition, as one Gauteng doctor noted, a 'severe' shortage of first-line antibiotics meant that 'much more potent and expensive ones had to be used to treat simple infections'. This was 'bad practice and could lead to antibiotic resistance, but clinicians had no choice'. [*The Times* 18 May 2015]

Dr Motsoaledi blamed the deficits on a global shortage of the active ingredients needed for various medicines, while a national survey by Stop Stock-outs found that manufacturers had difficulty in supplying in roughly 20% of cases. But the survey also showed that 80% of the shortages were due to logistical problems. Reported *Business Day*: '[Stop Stock-outs] said that 80% of reported cases were due to challenges between medicine depots and clinics at provincial and district levels, such as incorrect quantities of drugs ordered, inaccurate forecasting, and poor stock management'. Often, as the *Mail & Guardian* added, 'the medicine was in fact available at the storage depot – but the drugs could not be traced because there was no proper record-keeping system'. [*The New Age* 20 May, *Business Day* 25 May, 8 June, *The Citizen* 11 June 2015, *Mail & Guardian* 12 June 2015]

Treatment delays

Delays in treatment have long been common, and again the situation remains unresolved. In 2015, for instance, at the Chris Hani Baragwanath Hospital in Soweto, thousands of patients were on long waiting lists for various surgical procedures. In March 2015, a 56-year-old man, Aubrey Moreane, who urgently needed hip replacement surgery, was told he would have to wait seven years for this. Overall, there were close on 5 000 patients waiting for operations, of which more than half needed cataract procedures. In June 2015, however, Gauteng health MEC Qedani Mahlangu acknowledged that the cataract backlog was even worse than previously admitted, with more than 6 000 patients waiting for cataract surgery. Many of these individuals had been waiting for up to three years to be operated on. [*The New Age* 6 March, *The Star* 6 April, 24 June 2015]

Financial mismanagement

South Africa allocates around 12% of budgeted government spending to public health care, amounting at present to some 3.5% of GDP. In nominal terms, the health budget has increased by some 975% since 1994, while in real terms it has gone up by an average of 8.5% a year over the last five years or so. Primary health care expenditure per capita has almost doubled in real terms from R666 in 2005/06 to R1 100 in 2010/11. [IRR, *Fast Facts*, March 2016, pp3, 11; Kane-Berman, From *Last Grave at Dimbaza*, p3] However, South Africa gets little bang for its health care buck.

Financial mismanagement is a key part of the reason. In June 2015 a study carried out by the School of Public Health at the University of the Witwatersrand reported that the health care system was ‘sick with corruption and haemorrhaging money in irregular spending’. The study, carried out by Professor Laeticia Rispel and two of her colleagues, was based on reports by the auditor general over nine years, interviews with leaders in healthcare, and an analysis of media reports. It found that R24 billion of provincial health department expenditure between 2009 and 2013 was ‘irregular’ (not in keeping with procurement procedures), though not necessarily corrupt. The number of provincial health departments receiving unqualified audits had also decreased, from seven in 2004/05 to three in 2012/13. [*The Times* 26 June 2015]

Many health department employees said they felt ‘disempowered’ and unable to act against corruption and irregular spending, while a trade unionist told the researchers: ‘If you are a strong manager, you get targeted and destroyed. If you want to keep your job, you become corrupt yourself.’ The chief executive of a state hospital added: ‘Attitudes are appalling. People know that they can get away with it.’ The national health department said it was ‘concerned about corruption and encouraged people to report it regardless of who the perpetrator was’. However, the researchers cautioned that much stronger leadership and a good deal of ‘political will’ was needed to target it effectively. [*The Times* 26 June 2015]

Poor supply chain management and a failure to pay suppliers have also contributed to shortages of medicines, medical equipment, and other supplies. In addition, vacant posts

often cannot be filled because a provincial department has overspent in previous years and now has to cut costs. This, in turn, has contributed to a loss of nursing staff, who find themselves so overburdened that they prefer to resign. [*The Times* 14 August 2012]

In 2014 the Free State provincial health department was placed under the administration of the provincial treasury because it was no longer considered fit to manage its own budget. From 2013 to 2015 the Limpopo health department was under national administration, because suppliers had not been paid. From 2012 to early 2014, the Eastern Cape health department was under the partial administration of the provincial treasury department for the same reason. [*Mail & Guardian* 20 March 2015]

By 2015 the National Health Laboratory Service (NHLS) was in a critical condition because provincial administrations had failed to pay the billions of rand they owed to it. As a result, as the *Mail & Guardian* reported, 'it was in debt to the tune of R5bn and was leaking skilled staff, while many of the employees who remained were demoralised'. The NHLS provides vital diagnostic tests for all nine provinces. Among other things, it is responsible for most HIV and TB tests in the public health system and plays a critical role in screening for cancer. Moreover, without diagnostic tests, doctors are in the dark in treating many patients and cannot prescribe the drugs in fact required. [*Mail & Guardian* 9 January 2015]

According to Professor Francois Venter of the Wits Reproductive Health and HIV Institute, 'the NHLS is being held hostage by KwaZulu-Natal and Gauteng, which owe the lab millions'. Dr Motsoaledi denies this, instead blaming the NHLS for a 'chaotic, glitch-riddled billing system'. He wants the NHLS to be paid directly by the National Treasury in future, but questions remain as to how the massive debt already accrued will be paid. In the interim, staff losses are having a major impact on its operations. Said an insider (who preferred to remain anonymous): 'In the last year, 30 pathologists have left – and we already had fewer than we need. We've lost all their years of experience. They are leaving through sheer frustration. We've also lost 30% of our technologists. People with ten years' experience are being replaced by people fresh out of college.' Added another: 'Labs are being forced to consolidate, which means the smaller labs are being swallowed up. Lab managers have to beg for gloves and struggle to get stock. Staff members also wait anxiously each month to see if they have been paid.' [*Mail & Guardian* 9 January 2015]

Avoidable deaths

As standards of public health care have declined, so avoidable deaths have risen. In May 2015 a report compiled by the South African Medical Research Council (founded in 1969 to promote health through research, development and technology transfer) found that more than 80 000 newborn babies had died within two years as a result of negligence and the poor quality of healthcare in public hospitals. Many of the deaths could have been avoided if healthcare workers in these hospitals had followed simple guidelines, such as monitoring the heart rate of the foetus and looking after the overall health of the mother. [*City Press* 24 May 2015]

The report, entitled Saving Babies, tracked the number of live births against the number of neonatal deaths (deaths within 28 days of birth) at 588 health facilities between January 2012 and December 2013. It also examined why newborn babies had died. Out of the 82 453 deaths recorded in the report, about 44% had occurred at district hospitals. The majority of them were stillbirths, but many babies had also died because of oxygen deprivation during birth. Professor Robert Pattinson, co-author of the report, said most of the deaths could have been avoided if proper prevention methods had been followed. He noted that some improvements had been made, but stressed the need for further changes. 'The key aspect is to improve the quality of care', he said. [*City Press* 24 May 2015]

South Africa's maternal mortality rate, by the standard metric of deaths per 100 000 live births, increased from an estimated 150 in 1998 to 369 in 2001 and worsened further to 625 in 2007. More recent figures put the rate at 140 deaths per 100 000 live births, which shows the positive impact that effective ARV treatment for HIV/AIDS has had. However, South Africa's maternal mortality rate (140) is still very high compared to those in countries with similar per capita income levels: 68 in Peru, 64 in Colombia, and 27 in China. [*Business Day* 10 May 2016]

A key cause of maternal deaths is bleeding before or after labour. About 16% of mothers who die before or shortly after birth die from blood loss. About a third of these women die from bleeding out during or after Caesarean sections. In about 70% of cases, the deaths of women during or after C-sections could have been prevented, according to a recent review of maternal death audits published in the *South African Medical Journal*. The underlying reasons are a dearth of surgical skills in rural hospitals, a lack of emergency blood supplies, and delays in calling for help. [*The Star* 6 May 2016]

Medical negligence

In many instances, babies have survived poor care at birth but have been left badly brain damaged. An increasing number of medical negligence cases – many of them involving children harmed in this way – have thus been brought before the courts in recent years. In one case the Pretoria High Court awarded R23m in compensation to four-year-old Ntsako Mathebula, who was left with cerebral palsy, mental retardation, epilepsy, and other severe medical and developmental problems when medical staff at Tembisa Hospital on the east Rand failed to perform an emergency caesarean on his mother in November 2010. In another case, the North West MEC of health was ordered to pay more than R5.6m in damages to compensate a 12-year-old boy for negligence during his birth. In yet another instance, the Gauteng health MEC was ordered to pay more than R8.3m as compensation for Carlisle Buys, who was left a cerebral quadriplegic through the negligence of staff at a district hospital in Pretoria. [*The Star* 16 October, *The Citizen* 8, 19 June 2015]

Another botched birth resulted in 2015 in the awarding of R5m in damages against the Gauteng MEC for health. In this instance, Kamogelo Kau suffered a low blood sugar induced brain injury when his mother Christinah gave birth to him at the Pholosong Hospital in Tsakane (Brakpan) in 2006. His brain injury was aggravated by a lack of oxygen after his

birth and by poorly treated convulsions, which left him with severe cerebral palsy. Reported *The Citizen*: 'The boy's movements are impaired. He suffers from spasticity and quadriparesis and cannot walk, run, or sit for long periods. His speech has been severely affected, he is incontinent, and he moves by performing a kind of "bunny hop". An occupational therapist described the loss he had suffered as devastating not only for him but also his mother and family as he would never be able to live independently.' [*The Citizen* 21 September 2015]

Significant damages awards have also been made in various other cases which came before the courts in 2015. The Limpopo health MEC, for instance, was ordered to pay R1.25m in damages to a Thabazimbi businessman who lost his leg and his business because of shoddy treatment at a state hospital in the town. The Gauteng health MEC was ordered to pay R450 000 in compensation to a Witbank receptionist whose husband died after a gastric tube was inserted into his lung instead of his stomach. The Johannesburg high court awarded Brenda Mavimbela R13m in damages for the mistreatment of her 18-month old daughter, Nonjabulo, at the Far East Rand Hospital. The toddler was treated for bacterial meningitis when in fact she had tuberculous meningitis. As a result, she became permanently disabled. She is blind and cannot talk, walk, or feed herself.' [*The Citizen* 21 April, 27 February, *The Star* 17 August 2015]

In October 2015 the MEC for health in Gauteng, Qedani Mahlangu, told the provincial legislature that her department had paid out a total of some R544m for medical negligence claims dating back to 2010. The MEC reported that 168 claims had been lost in court, while eight had been settled. As *The Sunday Independent* reported, 'the individual cases make for harrowing reading', while 'many of them point to negligence of a shocking nature'. The newspaper report went on: 'One example is patient Shabbier Nagel, who had a leg amputated when he went in for heart surgery. Others are eight-year-old Ntokozo Skhosana and Nicholas van Niekerk, who suffered brain damage as a result of negligence. Five-year-old Thembisa Kometsi was awarded R4.6m after her legs were amputated when she was admitted to the Far East Rand Hospital with burns on her hands. According to evidence in court, Thembisa had developed gangrene due to conditions that were not addressed in accordance with "generally accepted norms and standards of good medical and nursing practice at the hospital".' [*The Sunday Independent* 6 September 2015]

The claims paid out by the Gauteng health department were small, however, compared to the R1.2bn paid by the Department of Health over the same period. By March 2015, the value of medical negligence claims lodged against the Gauteng department had skyrocketed from R6.6bn to R10.1bn, while the government's overall contingent liability for medical malpractice lawsuits amounted to R25bn. [*The Sunday Independent* 13 September, *The Star* 9 September 2015, *Business Day* 11 March 2015]

Dr Motsoaledi blamed personal injury lawyers for the increase, saying they were 'creating a national crisis' through their 'unprofessional conduct' and excessive charges'. He also suggested that lawyers no longer able to make money under the revised rules of the Road

Accident Fund (which limit the compensation payable to road accident victims and disregard the question of fault) were now looking to boost their coffers by taking on medical negligence claims. In an interview with the *Sunday Times*, he added that '[some] state lawyers were deliberately mishandling cases because they're being paid to'. Hospital staff were sometimes also involved, for they would steal a file proving that the doctor had not been negligent. However, as *Business Day* commented in an editorial: 'If the courts are awarding large amounts in damages, it is surely because malpractice is being proved.' Curing this should be the minister's focus, rather than trying to prove that lawyers were conspiring with state doctors and health department officials to milk the public health care system. [*Business Day* 10, 11 March, *The Sunday Independent* 13 September, *Sunday Times* 22 March 2015]

Auditing standards at public health care facilities

In 2012 the Department of Health released the results of a 'baseline' audit of health standards at some 3 900 public hospitals, clinics and other health facilities. The report found that average compliance scores (on six ministerial priority areas) were 30% on 'positive and caring attitudes', 34% on 'improving patient safety and security', 50% on 'infection prevention and control', 50% on 'cleanliness', 54% on the 'availability of medicines and supplies', and 68% on waiting times. Average scores on compliance in five functional areas were still worse: 53% on 'patient care', 45% on 'support services', 40% on 'infrastructure', 43% on 'management' and 38% on 'clinical services'. [Kane-Berman, From *Last Grave at Dimbaza*, p3; Serfontein, FMF presentation, 20 April 2016]

Some compliance scores were even worse. The availability of essential drugs in clinics was a 77% 'failure', while the score for vital health technology in maternity wards and operating theatres was a 93% 'failure' in both instances. Only two facilities could guarantee patient safety. All of this, the audit stated, was despite the fact that public sector health funding had increased by an average of 8.5% a year in real terms over the past five years. [Kane-Berman, 'From *Last Grave at Dimbaza*', p3; *Business Day* 24 May 2016]

Dr Motsoaledi described the audit outcomes as 'appalling'. They also suggest, of course, that little has in fact been done to improve the quality of management. As John Kane-Berman, policy fellow at the IRR, has commented: 'Hospitals and clinics don't run themselves. When things go wrong on the scale revealed, it is not the result of happenstance or bad luck or just one of those things. It is the result of decisions made or actions taken – or not taken – by those people.' [Kane-Berman, '*From Last Grave at Dimbaza*', pp3-4]

In 2013, in an attempt to overcome these problems, the Office of Health Standards Compliance Act was adopted. Dr Motsoaledi said that inspectors from this office would in future 'visit hospitals unannounced' to assess issues such as cleanliness, staff attitudes, infection controls and the availability of medicines. However, wrote journalist Moshoeshoe Monare in *The Sunday Independent*: 'The health minister wants another layer of bureaucracy to deal with what the provincial departments of health, hospital CEOs, and nursing matrons are supposed to be attending to… If the nursing and medical staff are unable to attend to patients, disciplinary action – not a lengthy process to the ombudsman – must be taken

immediately. Lack of discipline, professionalism and poor service are a reflection of the managerial and leadership ethos, and no external person or body will fix it.' [*The Sunday Independent* 8 July 2012]

The Office of Health Standards Compliance (OHSC) was established the following year, while in 2014/15 the OHSC re-inspected 417 state facilities. The results were dismal, for only 3% of these facilities were found to be 'compliant'. Another 13% were compliant 'with requirements' or were 'conditionally compliant'. The remaining 84% were non-compliant, of which 16.5% were 'conditionally compliant with serious concerns', 27.8% were 'non-compliant' and 39.8% were 'critically non-compliant'. [Serfontein, FMF presentation, 20 April 2016]

Given this high level of non-compliance, it is not surprising that Dr Motsoaledi has yet to promulgate binding norms and standards to cover all health facilities in both the public and the private sectors. Were he to do so, only 16% of public health facilities would qualify for certification by the OHSC. Yet until such time as binding standards are prescribed, the OHSC cannot act to enforce compliance. In addition, without the appointment of many more inspectors – for which no revenue is available – the OHSC will not be able to extend its inspections to the private health care sector. This has huge ramifications for the NHI system, for it means that the private sector will be unable to obtain accreditation to participate in it. This means that 55 million South Africans will have to be served by the 16% of public facilities currently compliant with OHSC norms and standards. [*Business Day* 24 May 2016; Serfontein, FMF presentation, 20 April 2016]

The NHI the supposed solution

According to the White Paper, the solution to these problems in public health care is to introduce the NHI system, which will pool private and public funding for healthcare, draw on the services of both private and public health care professionals, allow economies of scale through the centralized purchasing of medicines and other supplies, limit the money now spent on administering medical schemes, ensure that all health services are free at the point of service and 'provide universal access to quality, affordable personal health services for all South Africans', both rich and poor. [Para 51, White Paper]

However, there are major flaws in this vision of the benefits of NHI. In addition, though the White Paper is in its 40th iteration, there is still no clarity on many essential points, from the benefits to be provided to the costs of the NHI and how these costs will be met in an economy unable to afford major increases in public spending.

Compulsory membership

As the White Paper notes, the NHI is intended to introduce universal health care coverage. Membership of it will thus be compulsory, irrespective of whether people want to participate in it or not. They will not be compelled to use the services it provides, but they will be obliged to help pay for it. In addition, since the NHI will effectively put an end to most

private medical schemes, most individuals will in practice have no choice but to rely on it. [The Times 22 January 2016]

Benefits to be provided

According to the White Paper, the NHI will provide 'a comprehensive package of personal health services'. However, since resources will be limited, it will have to prioritise and 'will not cover everything for everyone'. [Para 125, White Paper]

The White Paper adds that the NHI's 'comprehensive package' will include preventative, curative, rehabilitative and palliative health care services. It will also cover HIV/AIDS and TB services, optometry, speech and hearing, and mental health services, along with 'prescription medicines', 'chronic disease management', and 'diagnostic radiology and pathology services'. All included will be 'reproductive', maternal, paediatric, and child health services, along with emergency care. [Para 131, White Paper]

Within this broad range, the benefits that will in fact be made available will be decided by the 'NHI benefits advisory committee', which will 'develop service entitlements for all levels of care', from primary to quaternary (the most specialised of all). The White Paper states that 'the range of services will be regularly reviewed using the best available evidence on cost-effectiveness, efficacy, and health technology assessments'. [Para 130, White Paper] What this also means, however, is that bureaucrats will decide what should be included, while patients will have little or no say. Nor will doctors, specialists, and other health care professionals necessarily have much influence over the decisions of this committee.

The White Paper adds that 'irrespective of how comprehensive the NHI entitlements will be, some personal healthcare services will not be covered'. Certain dental services could be excluded, for example, but might be covered via the 'complementary' services that medical schemes will be allowed to cover (see *The role of medical schemes*, below). [*Saturday Star* 19 December 2015]

The White Paper also makes it clear that the services ultimately to be provided will not be similar to the prescribed minimum benefits (PMBs) currently provided by medical schemes. This, it says, is because such benefits 'cover only a limited number of health conditions, and are essentially hospi-centric without fully addressing the burden of disease'. The NHI's emphasis is thus on preventative, rather than curative services. But this seems to disregard the existing burden of disease within the country. [Para 132, White Paper; *The Times* 22 January 2016]

'The point of entry' will be at the primary health care level, and patients who need specialists or hospital treatment will have to be referred upwards from the primary level. Anyone who goes directly to a specialist, for example, will pay what the White Paper calls a 'bypass fee'. [*Saturday Star* 19 December 2015]

Costs of the NHI

The White Paper dismisses the need for accurate forecasting of the costs of the NHI, saying 'it is not useful to focus on getting the exact number indicating the estimated costs'. Countries which have tried this, it adds, have 'ended up tied to an endless cycle of revisions and attempts to dream up new revenue sources'. Hence, 'the question of "what will the NHI cost" is the wrong approach'. [Para 250, White Paper]

Dr Motsoaledi has long been similarly dismissive of the need for accurate costing, saying in 2011, for example, that 'there was no point in projecting how much the NHI would cost as the figures would have to be adjusted'. His department has added that 'a 100% accurate estimation of the cost of NHI is not possible as it depends on utilisation rates and the size of the population, as well as unit costs'. In releasing the White Paper in December 2015, Dr Motsoaledi spoke again about the affordability of the fund, saying 'it could cost anything up to R1 trillion' depending on how it was planned. 'What it costs will depend entirely on how we design it,' he said. [*Business Day* 23 September 2011, *Mail & Guardian* 28 October 2011, *Saturday Star* 12 December 2015]

The White Paper nevertheless estimates that 'total NHI costs in 2025 will be R256bn (in 2010 terms)'. This projection assumes that 'NHI expenditure increases by 6.7% a year in real terms after 2015/16… This would take the level of public health spending from around 4% of GDP currently to 6.2% of GDP by 2025/26, assuming the economy grows at an annual rate of 3.5% of GDP'. On this basis, the NHI funding shortfall would fall between R28bn and R108bn, depending on how fast budgeted revenues for health care were to expand. [Para 252, Table 1, Para 253, White Paper]

The Democratic Alliance (DA) and other analysts have dismissed these projections as 'little more than a thumb-suck'. Says the DA's Wilmot James, shadow minister of health: 'There is no evidence in the White Paper of Treasury's assessment of the costs; but simply a projection based on 2010 prices'. Journalist and author R W Johnson notes that the long-anticipated White Paper on the NHI was supposed to be presented together with the Treasury's cost projections. Instead, the document was suddenly released, without the Treasury's input, soon after the unexpected dismissal of finance minister Nhlanhla Nene. He suggests that Dr Motsoaledi 'grabbed the chance' to move ahead with the NHI proposal 'at a time when the Treasury was in disarray' and less able to resist what it has long regard as 'an unaffordable dream'. [*Business Day* 14 December 2015; R W Johnson, Where to now?, Politicsweb.co.za 14 December 2015]

In these circumstances, the cost estimate put forward in the White Paper lacks credibility. It also seems unrealistic. Back in 2009, when the ANC released a 200-page discussion document on the NHI, Dr Jonathan Broomberg, chief executive at Discovery, said: 'If the NHI were to provide the current package of benefits provided to the average member of a medical scheme to the entire population, this would cost about R497bn, equivalent to 20% of GDP (at present the fiscus spends 3.5% of GDP on health).' If cover were to be limited to the prescribed minimum benefits (PMBs), this too would cost far more than the White Paper

estimates. At present, medical schemes need around R600 per person per month to cover the PMBs. On this basis, the cost of providing these benefits to 55 million South Africans, in 2025 alone, will be R396bn rather than R256bn. [*The Star* 3 June 2009, *Business Day* 29 July 2015, Mail & Guardian 22 January 2015]

Unless GDP grows significantly – which is unlikely with the country standing on the brink of credit downgrades and recession – R396bn would amount to roughly 10% of GDP. This cost estimate also fails to take into account the cost of the large bureaucracy the White Paper proposes to implement the NHI. It also overlooks the potential for fraud, corruption, inflated prices for medical supplies, and general inefficiency – all of which could raise NHI costs still higher.

However, if the Department of Health is able to divert all current expenditure on health care by itself, the provincial administrations, and other state entities into the NHI Fund, along with all current expenditure on medical aid schemes, medical insurance, out- of-pocket payments, and the like, then a projected NHI cost of R396bn in 2025 would be roughly the same as the R377bn in total health expenditure expected in 2016/17. [Para 259, Table 2, White Paper] On this basis, says Dr Humphrey Zokufa, executive director of the Board of Healthcare Funders, the NHI would be affordable. [*City Press* 13 December 2015]

However, this will depend on the national department being able to strip all provincial administrations of their current role in providing healthcare services. This will also have to be done as regards the departments of defence, correctional services and education – plus all municipalities with their own health revenue, the Workmen's Compensation Fund, and the Road Accident Fund. Significant resistance is likely: especially from the nine provincial administrations, which have concurrent jurisdiction over health services under the Constitution and which currently spend the bulk of the public health care budget (R160bn out of R183bn in 2015/16). [*Business Day* 14 December 2015; Para 259, Table 2, White Paper]

More seriously still, it also depends on the government being able to extract from a relatively small pool of taxpayers as much they now voluntarily spend (some R190bn) on the effective and efficient private health care of their choice. [Para 259, Table 2, White Paper] The White Paper suggests that taxpayers must be willing to do this as part of an essential social solidarity. It also implies, as an article in the *Financial Mail* points out, 'that people who pre-fund their own health care by contributing to medical schemes [out of after-tax income] somehow drive inequality. But this is like saying parents who send their children to private schools or employ private security guards do the same thing'. [*Financial Mail* 25 February 2016]

Commented *Business Day* in an editorial: '[The White Paper] offers no meaningful new data on what [the NHI] will cost, how it will be paid for, and by whom… Without thorough and realistic costing, however, the NHI will remain in the realm of fantasy. A separate Treasury paper on the financing of the NHI was long promised, but no representatives of the Treasury were present when Dr Motsoaledi released the White Paper… Instead, the document used

R256bn, a number hardly different from the estimate in the [green paper] in 2011. It also relies on an economic growth projection of 3.5% a year that now seems fantastical given that growth is stuck at 1.5% or less.' [*Business Day* 17 December 2015]

Funding the NHI

As noted, the NHI assumes that the economy will grow by 3.5% of GDP a year. This projection is taken from the green paper. It overlooks the fact that the economy has not grown at this rate since 2011 and is unlikely to grow at all in 2016. In addition, South Africa is likely to have its sovereign credit rating downgraded to sub-investment (junk) status by the end of this year. This will increase the government's already very high borrowing costs and make it more difficult for it to fund its annual interest bill, which already consumes more than 10% of budgeted expenditure and has long been the fastest-growing line item in the budget. [*Fast Facts*, March 2016, p4] With higher interest rates and reduces revenues, the government will also battle to contain public debt, which has doubled over the past eight years and now stands at around R2 trillion. Junk status will also deter investment, reduce the value of the rand against the dollar and other major currencies, worsen inflation, and tip the country into recession. On this basis, it will be very difficult to sustain GDP at its current levels, let alone increase it.

The White Paper assumes that the necessary funding can be acquired by pooling all current public and private health care funding, in the manner already outlined. It also says that 'declining medical scheme contributions can be offset by a rise in general tax allocations to be directed towards the NHI'. It identifies three possible sources of increased tax revenue: a surcharge on personal income tax, a payroll tax, and an increase in the rate (14%) at which Value Added Tax (VAT) is levied. [Paras 263, 277, Table 3, White Paper]

At the same time, the White Paper acknowledges that 'payroll taxes can have unintended negative… consequences …on overall employment and job creation'. It notes that the current VAT rate, at 14%, is 'moderate by comparison with the international average (16.4%)' and agrees that consumption taxes are 'less distortionary in their impact' on employment and the wider economy. However, it is also concerned that VAT is regressive and places a disproportionate burden on the poor. That leaves a surcharge on personal income tax, where the highest marginal rate has recently been raised to 41%. Yet increasing the tax rate here, the White Paper notes, 'would impact on the disposable income of households and could only be phased in with due regard to the impact on consumption expenditure and economic activity'. [Paras 285, 291, 292, 287, 288, White Paper]

In assessing the magnitude of the tax increases that might be necessary, the White Paper assumes that the revenue shortfall will be R79.1bn in 2025. But this figure is unrealistic. As earlier noted, NHI costs are likely to be far higher, while GDP is likely to contract rather than expand over the next nine years. Based on these flawed premises, the White Paper further assumes that the shortfall could be bridged via a 1% payroll tax, coupled with a 1 percentage point increase in the marginal rate of personal income tax and a 1 percentage point increase in the VAT rate. Alternatively, it suggests (among other things) that the shortfall could be met

via a 4 percentage point increase in the marginal rate of personal income tax. [Para 297, White Paper]

However, the Davis Tax Committee currently investigating the tax system in South Africa has warned that South Africans are already very highly taxed, leaving very little scope to raise taxes yet higher. The tax base is also very small. In the 2014/15 financial year, for instance, only 10% of the 4.9 million individuals assessed for tax earned more than R500 000 a year. This group, comprising roughly 490 000 people, contributed some 57% (or R140bn) of the R246bn in assessed personal income tax that year. [2016 *Survey*, p178] These better-skilled and higher-earning individuals, both black and white, already get very little back for their tax payments in the form of public services, preferring (because of quality concerns) to pay for private education, private healthcare and private security out of their after-tax income. They could also be so alienated by the NHI – and the decline in the quality of healthcare that it will surely bring about – that many may choose to emigrate. Yet the White Paper implicitly assumes that some R190bn (and more) can be extracted in additional personal taxes from this small group.

The White Paper also overlooks the extent of unemployment in South Africa and the fact that other countries that have introduced universal health coverage (not necessarily in the same form as the NHI) have a much bigger tax base and significantly less unemployment. Mexico, for example, has a tax base of 47.8% and an unemployment rate of 4.8%, while Thailand has a tax base of 29% and a jobless rate below 1%. Brazil has a tax base of 25% and an unemployment rate of 6.8%. By contrast, South Africa has a tax base of 10.3% and unemployment at 25.4%. [Serfontein, FMF presentation, 20 April 2016]

The White Paper further assumes that more revenue can be obtained from carbon tax, which is expected to generate about R8 billion a year. However, this would be a drop in the ocean of the NHI need, while this tax is also supposed to be used for mitigating the impact of climate change, not funding healthcare. It suggests that 'additional revenue could be mobilised from current employer contributions to medical schemes', such as the Government Employees Medical Scheme (GEMS), the Police Medical Scheme, the Parliamentary Medical Scheme, the Municipal Workers Medical Scheme, and the like, to which the state currently contributes some R20bn. However, public service unions may strenuously resist this change, especially if their members are then forced to rely on a bureaucratic and ineffective NHI. The White Paper also proposes doing away with some R16bn in tax credits currently allowed for medical scheme contributions, so as to make medical aid more affordable and reduce the burden on the public healthcare system. [Paras 305, 308, 261, 309, White Paper] Again, however, this change is unlikely to be popular with the country's public servants or the other people currently belonging to such schemes.

Overall, the White Paper's proposals for the funding the NHI system are unrealistic and poorly thought through. In essence, given South Africa's bleak economic forecast, unemployment crisis, narrow tax base, and already ballooning public debt, the country simply cannot afford the NHI. [*Business Day* 4 February 2016] Nor does it need this when far better

ways of achieving a higher level of universal health coverage are available [see *Alternatives to the NHI*, below).

Increased, rather than reduced, health care costs

The White Paper assumes that the NHI system will bring down health care costs as all medical practitioners, including those in the private sector, will be compelled to charge capitation fees (a fixed amount per person treated), rather than a separate fee for each service rendered, as many do now. In addition, it suggests, a centralised procurement system for medical services, pharmaceuticals, and other goods will help contain costs through economies of scale, while the prices of medicines and other items will be controlled. [Paras 181, 345, 393.b.iii, 387, White Paper]

However, this overlooks the increased scope for price inflation and corruption in this state-controlled system. Since the government will dictate prices, market mechanisms will not be available for this purpose, which means that some prices are likely to be set too high while others will be set too low to maintain supply. In addition, without a market mechanism to assess the extent of demand, bureaucrats will have to decide on what services, medicines, and other goods will be needed when and where. Inevitably, there will be over-provision in some areas and under-provision in others. This will generate huge inefficiencies in the system as a whole, which will add to costs rather than reducing them.

The costs of the massive bureaucracy that will be needed to implement the NHI are also left out of account in the White Paper. However, each of the new administrative entities that it envisages will have to be staffed, equipped, and provided with appropriate office space. In addition, the complex tasks these entities will be expected to perform will not come cheaply either.

The new bureaucracy required

According to the White Paper, a host of new administrative and regulatory entities will be required, while a number of monitoring and other systems will also have to be established.

South Africa has 52 district municipalities, each of which has jurisdiction over a number of local authorities within its area. District municipalities cover all parts of the country other than the eight metropolitan areas. [2013 *Survey*, p857] Much emphasis will be given to primary health care, in which municipal- and district-based teams will play a vital part.

Municipal ward-based primary health care outreach teams (WBPHCOTs) will be established in each of the 4 000 municipal wards within the country. These will be led by a nurse, linked to a clinic, and staffed by community health workers who will assess the health status of households within the ward to identify those in need of ‘preventive, curative, or rehabilitative services’ and refer them to the local clinic or other primary health care facility. The White Paper sees these teams as ‘a game-changer’ in improving access to health care. [Paras 163-164, White Paper]

At the district level, there will be an 'integrated school health programme' to assess the health needs of some 12 million school pupils. Some 70 'school mobiles' have thus far been deployed in the ten NHI pilot districts, and assessed the needs of some 500 000 pupils in 2014. [Para 169, 170, White Paper] This suggests that each school mobile can deal with some 7 100 pupils. To cover 12 million pupils, some 1 690 school mobiles will be needed.

Each district will also have a district clinical specialist team. Each such team is to have seven members, including specialists in obstetrics, gynaecology, and paediatrics. These teams will help with capacity building and mentorship, while 'strengthening the use of the clinical guidelines and protocols' to be decided by various other committees (see below). [Paras 174, 175, White Paper]

South Africa has close on 3 200 public clinics, each of will also need a 'clinic committee' to advise people and conduct health campaigns in its particular area. Guidelines have already been developed as to how these clinic committees should function [2016 Survey, p581; Para 186, White Paper] – and will no doubt need to be revised from time to time.

Each of the country's 52 districts will also have a new 'district health management office' (DHMO). These offices will be responsible for 'managing, planning and co-ordinating personal and non-personal health service provision, taking into account national health policy priorities and guidelines as well as health needs in the district'. [Para 187, White Paper] These health needs will presumably be determined by sifting and analysing the data to be provided by the ward-based teams, the school mobiles, the clinic committees, and each district clinical specialist team. Properly assessing and weighing the significance of all this information will in itself be a complex task.

Above the primary level, there will be hospitals of six different kinds, from district hospitals (providing generalist medical services) to central hospitals (providing highly- and super-specialized services). These will be contracted to provide health services in accordance with the norms and standards of the Office of Health Standards Compliance (OHSC). They will also be expected to comply with the benefits determined by yet another new entity, the NHI Benefits Advisory Committee. In addition, measures will be taken to improve the skills of hospital boards and, in time, to delegate more managerial autonomy to them. [Paras 193-198, 208, 211, 212, White Paper]

The OHSC will be responsible for assessing and accrediting all the health care practitioners and facilities, both public and private, which are to be drawn into the NHI system. It will have to assess each practitioner or facility in terms of 'seven domains and six national core standards'. The seven domains range from patient safety and clinical care to corporate governance, operational management (including financial, asset, and human resource management), along with facilities and infrastructure. The national core standards include cleanliness, staff attitudes to patients, infection control, security, waiting times, and availability of medicines. Health facilities that meet all these standards will be certified by the OHSC to 'render health services' and will then be 'eligible for accreditation and contracting

by the NHI Fund'. The OHSC has an inspectorate to help enforce compliance with these norms and standards, as well as an ombud to investigate complaints by patients. [Paras 215-218, White Paper]

In 2014/15, the OHSC, which has some 35 inspectors available for this purpose, managed to audit 417 public health facilities – only 16% of which, as earlier described, were found to be compliant with the requisite norms and standards. Yet South Africa has close on 3 200 public clinics, together with 407 public hospitals and 203 private hospitals, all of which would have to be assessed once every four years. There are also between 31 000 and 74 000 private health care practices in the country, all of which would also need to be inspected and certified, with mandatory re-inspection every four years. The numbers potentially qualifying for OHSC inspection are even higher, as registered health care professionals in South Africa include 41 100 GPs and specialists, along with 5 800 dentists, 4 300 occupational therapists, 6 700 physiotherapists, and 7 400 radiographers and (should this be applicable) roughly 270 000 nurses of various kinds. [*Business Day* 24 May 2016; 2016 *Survey*, p572]

Though not all registered practitioners are necessarily working in the country and not all may need or wish to be accredited, the scale of the assessment and accreditation task is nevertheless enormous. This is also not the end of the matter, for once the OHSC has identified a health facility or practitioner as 'eligible for accreditation', the actual task of accrediting and contracting with that health care provider still has to be carried out by another administrative entity (see below). [Para 217, White Paper]

To increase access to essential medicines and shorten queues at clinics and hospitals, a Centralised Chronic Medication Dispensing and Distribution (CCMDD) programme has been introduced. This has two components: Central Chronic Medicines Dispensing and Distribution (CCMDD) and Pick-up-Points (PuPs). Thus far, this programme has concentrated on providing ARVs to some 260 000 patients. [Paras 231-234, White Paper] It will need to be greatly extended to cover 55 million people under the NHI system.

The struggling National Health Laboratory Service (NHLS) is to be brought under greater state control to prevent 'unnecessary' tests and reduce fees. This will be done by 'categorising the 127 tests' currently most commonly ordered to assess 'individual health care needs'. Restrictions will be placed on the test methods that may in future be used, using new 'evaluation criteria'. Tests which fail to meet these criteria will be rejected. A capitation-based reimbursement model will be developed, under which 'the cost per test will be adjusted against the demographic (or disease) profile of the specific province, giving a cost per person for laboratory services'. [Paras 235-239, White Paper] Once these proposals are implemented, long delays in obtaining essential diagnostic test results, complex bureaucratic procedures, and inadequate funding for the NHLS are likely to result.

A National Health Commission (NHC) will also be established to advise on health promotion and disease prevention. It will focus, among other things, on 'preventing and managing diseases of lifestyle that are likely to pose a major threat over the next three decades'. The

commission will work together with government departments and a range of other stakeholders in addressing risk factors and securing 'multi-sectoral collaboration'. [Para 188, White Paper]

Also required, of course, will be the NHI Fund, into which all monies needed for the NHI will be paid and out of which all expenses will be paid. Many bureaucratic processes will be required in the establishment and operation of this fund. As the White Paper puts it: 'The creation of the NHI Fund will entail the establishment of functional, governance and accreditation structures and purchasing systems, risk mitigation systems, health technology assessment, as well as systems for monitoring and evaluation systems (sic).' [Para 15, White Paper]

Given the range and complexity of these functions, the NHI Fund will have eight sub-units, these being: a Planning and Benefits Design unit, a Price Determination Unit, an Accreditation Unit, a Purchasing and Contracting Unit, a Procurement Unit, a Provider Payment Unit, a Performance Monitoring Unit, and a Risk and Fraud Prevention Unit. [Para 326, White Paper]

The specific functions of each of these sub-units is not further explained. However, accreditation, for one, will be a complex process, in which the OHSC's confirmation of eligibility for accreditation will be just the start. Whether or not to accredit a particular facility or practitioner will depend, among other things, on the 'health needs of the population', the 'service package' to be provided, any particular 'location requirements', plus 'the routine submission of specified information'. This information must include diagnostic codes applied, drugs dispensed, diagnostic tests ordered, length of patient stays (in hospital, presumably) and discharge/separation information. Any decision on accreditation must also take into account 'the demographic (age/sex) composition and epidemiological profile of the resident or catchment population in each district'. In addition, providers are to be measured 'against indicators of clinical care, health outcomes, and clinical governance, rather than simply on perceived quality of service'. [Paras 332, 333, White Paper] None of these criteria will in practice be easy to assess.

The NHI Fund also 'will determine its own pricing and reimbursement mechanisms', in consultation with the minister. Payments to healthcare practitioners and facilities will be based on a 'risk-adjusted capitation formula', which takes into account 'key factors such as population size, age and gender and disease/epidemiological profile'. In addition, 'the annual capitation amount will be linked to the registered population, target utilisation, and cost levels'. Contracted providers will have to adhere to the 'treatment protocols' laid down for all the conditions included in the NHI package of benefits. To ensure that capitation fees do not result in under-servicing, there will be 'routine monitoring of provider practices'. This will include 'both peer review at the district level and monitoring by the NHI Fund through analysis of diagnosis, treatment and referral information'. [Paras 353, 354, White Paper] Assessing whether providers qualify to be granted or to retain their accreditation will thus be

a complex task, which will require constant monitoring of their performance by bureaucrats and other practitioners.

Where services are purchased from private specialists, the NHI will use 'a capped case-based fee, adjusted for complexity where appropriate', and this will be 'continuously reviewed taking into account access and budgets'. Payments to both public and private hospitals will increasingly be based on 'case-mix adjusted payments, such as Diagnostic-Related Groups'. (Such a system classifies patients according to their diagnosis and sets a single fee for their conditions. This is seen as giving hospitals incentives to manage their costs better, as they may no longer charge fees for all services provided.) According to the White Paper, the approach used will in time move towards 'global budgeting based on crude activity estimates' (as opposed to line-item budgeting or fees for services). This will require 'collecting basic data on hospital activities (outpatient visits, in-patient days and admissions) and average (as opposed to facility-specific) unit costs for different levels of care'. [Para 355, 356, White Paper; *Business Day* 25 September 2015]

As regard reimbursement for providers, the White Paper is concerned that the current 'fee-for-service' model 'allows the provider to receive payment regardless of how successful they were in improving the condition of the patient'. The NHI Fund will thus use its payment mechanisms to 'leverage the provision of efficient and quality services through linking provider payment to their performance and compliance with accreditation criteria'. At the same time, 'the reimbursement system will be regularly reviewed and refined taking into account implementation experiences'. [Para 348, White Paper]

Whether providers get paid or not will thus depend, it seems, on whether their patients get better: an issue which may not be under their control in the best of circumstances and will be further affected by the inefficiencies inherent in the NHI system. For example, if a doctor orders a diagnostic test which is delayed or refused by the NHLS (under the controls to be imposed on it) and the patient deteriorates in the interim, the doctor may not be paid his capitation fee. Moreover, the 'regular' reviews envisaged are unlikely to solve such implementation problems in the reimbursement system. However, they will surely give bureaucrats ever more work to do.

As the White Paper stresses, all service providers will be expected to adhere to mandatory treatment protocols. Some treatment guidelines have already been developed, in the form of the Standard Treatment Guidelines associated with the Essential Drug List (EDL). Under the NHI system, these guidelines will be 'reviewed and updated over a three-year cycle to take account of new technology and evidence'. They will also be supplemented by further guidelines, still to be developed, which will cover surgical procedures, anaesthesia, the treatment of malignancies, and other matters. 'The NHI Benefits Committee will thus establish Expert Committees to develop guidelines for the priority areas where there are currently gaps'. [Para 341, White Paper]

Since clinicians might sometimes regard these guidelines as too inflexible, the NHI Fund will also establish a Clinical Peer Review Committee to deal with this problem. This committee will use 'transparent and accountable processes' to mitigate any perceived inflexibility and help manage 'complications or co-morbidities'. [Para 342, White Paper]

The NHI Fund will also develop a National Health Information Repository and Data System. This system, the White Paper, says 'will be crucial for the implementation and effective management of the NHI and the portability of services for the population'. It will require 'an electronic platform with linkages between the NHI Fund membership database and the accredited and contracted health care providers'. It will be used, among other things, to 'monitor the extension of coverage', 'track the health status of the population', deal with 'all financial and management functions', monitor the 'utilisation of health care benefits by NHI members and how this information must be used to support planning and decision-making', provide 'quality assurance programmes', produce reports, and include 'research and documentation to support changes as the health care needs of the population change'. [Para 363, White Paper] An army of bureaucrats will be needed to marshal all this information for 55 million South Africans.

One component in the overall Information System will be the Health Patient Registration System (HPRS), which was launched in July 2013 in conjunction with the Department of Science and Technology and the Council for Scientific and Industrial Research (CSIR). The HPRS provides a Patient Registry and Master Patient Index (MPI) service, which records not only patients' ID (or passport) numbers, but also their personal details and the health services given to them. Thus far, some 555 000 patients have been registered (which leaves approximately 54.5 million people still to be captured in the MPI). Also to be created is a Health Provider Index (HPI), which will help link available providers to the patients on the MPI. [Paras 367-369, 371, White Paper]

As for the Risk and Fraud Prevention Unit, its key function will be to prevent the large amounts of money to be collected in the NHI Fund (R256bn according to the White Paper and R399bn more realistically) from being eroded through fraud and corruption. The White Paper thus stresses the need to prevent the 'abhorrent provider behaviour [and possibly] corrupt activities' which 'the trust relationship' between doctors and their patients makes possible. It also warns against 'fraud, abuse and waste' on the part of patients, doctors, and pharmaceutical companies. Patients, it says, could abuse the system by using fake IDs, seeking second opinions, or 'visiting facilities for minor health problems'. Doctors could make 'excessive use of medical equipment or drugs by not following recommended treatment guidelines'. Pharmaceutical companies could give doctors incentives to use their drugs or to 'over-prescribe'. [Paras 372-375, White Paper]

The White Paper also acknowledges the risk of 'regulatory capture, where those who write regulations bias them towards specific actors'. It notes that officials may not always be blameless, for 'suppliers may bribe officials to overcharge their services in return for kickbacks', while officials could also 'benefit non-qualified suppliers in return for

kickbacks'. Managers might 'award contracts to inappropriate or unaccredited providers or issue fraudulent NHI cards to non-beneficiaries'. In addition, staff at hospitals and other facilities could 'help themselves to medicines, linen and other supplies', causing further losses. [Paras 372, 375-377, White Paper]

To guard against these dangers, the White Paper proposes a comprehensive risk management process, involving 'seven risk management steps'. The first step will be to appoint 'a risk management co-ordinator and a risk management committee'. An 'approach for risk management' will be developed (the 'NHI Risk Engine'), which will be supplemented by 'a risk assessment matrix', 'a risk register', and 'a risk management framework'. This framework will 'utilise the concept of clinical pathways to facilitate automatic and systematic construction of an adaptable and extensive fraud-detection model' (whatever that may mean). Risk management will also be incorporated into performance monitoring, while 'a proactive risk identification and fraud prevention strategy will be developed to capture those who engage in fraudulent activities'. [Para, 383, 377-378, White Paper] These paper exercises, the White Paper seems to assume, will then suffice to do the job.

The White Paper also notes the need for a system of 'health technology assessment'. Though it fails to acknowledge the rapid pace of medical innovation in the 21st century, it wants bureaucrats to decide on the 'introduction of interventions for health promotion, disease prevention, diagnosis, treatment, and rehabilitation'. New technologies are unlikely to be approved unless officials are satisfied that they will make for a more 'efficient use of resources' in the context of 'a sustainable health system'. The expensive new drugs which medical schemes are derided for not covering are unlikely to be included in the NHI benefits package, as the key criterion will be 'whether they are more cost effective than existing health service interventions'. [Para 384, 393.a.iv, White Paper]

In May 2016, for example, Dr Motsoaledi criticised pharmaceutical companies for their 'devilishly unaffordable' new cancer drugs, adding that if prices were not brought down, 'the country would be counting body bags as if it were at war'. But expensive new medicines are even less likely to be made available under the NHI. This will increase the risks that untreated patients, in the health minister's words, will simply be 'left to die'. [News24, 10 May 2016]

Price controls for medicines and health products will also be introduced. As the White Paper puts it, 'a formulary listing the prices of medicines and health products will be established nationally'. Centralised procurement of all 'health-related products, including medicines, devices, equipment, consumables, and other products' will bring many benefits, the White Paper claims. Apart from the economies of scale that will arise, 'the advantages of price determination could save millions of rands every year'. [Paras 387-388, White Paper] It could also, of course, cut patients off from a host of medicines and other medical products which the shrinking rand has pushed above the relevant price limits.

In addition, there will be ‘a national health products list’ which will set out what is allowed at different ‘provider levels’. According to the White Paper, ‘the selection of medicines and other health technologies will be based on the burden of disease, efficacy, safety, quality, appropriateness and cost-effectiveness’. Another army of bureaucrats will be needed to make these decisions, especially as ‘the list will be reviewed on a regular basis to take account of changes in the burden of disease, product availability, and price-changes based on evidence’. [Para 387-389, White Paper]

The White Paper sums up the extent of the control the state will wield, saying: ‘The government will put into place the necessary regulatory and policy interventions to determine tariffs for health services (including provider tariffs and prices for pharmaceuticals and related products. The law will equally apply to public and private providers, including suppliers of medicines.’ [Para 393.b.iii, White Paper]

Yet another bureaucratic structure will be required in the form of the NHI Commission. This will oversee the NHI Fund and ensure (the White Paper says) that ‘the NHI Fund is accountable and that the interests of the general public are taken into account’. The NHI Commission will include experts in relevant fields, including health care financing, public health, health policy and planning, epidemiology, actuarial sciences, taxation, and ICT. It will also include civil society representatives. The NHI Fund will report on a quarterly basis to the NHI Commission and on an annual basis to Parliament. Specific performance indicators will be developed against which the Fund will routinely be assessed. [Para 329 (as included on page 62), White Paper]

The role of medical schemes

According to the White Paper, the NHI will be funded through ‘mandatory prepayment’ into the NHI Fund. Hence, ‘individuals will not be allowed to opt out of making the mandatory prepayment towards NHI, though they may choose not to utilise the benefits covered by the NHI Fund’. [Para 395] In itself, this aspect of the NHI will be enough to put the future of many medical schemes at risk, for many of the people who now have medical aids will not be able to afford both the additional taxes required to fund the NHI and their medical scheme contributions.

More seriously still, the White Paper (unlike the green paper before it) now seeks to confine medical schemes to covering only those services that are not available through the NHI. According to the White Paper, medical schemes will play ‘a supplementary role’ in the period when the NHI is being established. This means that individuals with the necessary means will still be able to use their medical schemes to access medical services, even if those services fall within the ambit of what the NHI covers. However, the White Paper goes on, ‘once the NHI is fully implemented, medical schemes will offer complementary cover to fill gaps in the universal entitlements offered by the state’. [Para 399, White Paper]

The document adds: ‘In future, all medical schemes will offer only complementary cover for services that are not included in the health service benefits and medicines approved by the

NHI Benefits Committee. The cover provided by medical schemes must only complement (and not duplicate) the NHI service benefits.' Towards this end, it says, there will be 'a complete overhaul of the existing prescribed minimum benefits regime', presumably so as to ensure that most of these are included in the NHI package and the population is thus 'granted the greatest possible access to health care services…within available resources'. When the NHI is fully implemented, the White Paper thus anticipates that 'the number of medical schemes will reduce from the current 83 to a much smaller number'. [Paras 401, 402, White Paper]

The White Paper rejects any notion that the complex task of administering the NHI Fund should be outsourced to existing medical schemes, with their significant expertise and experience. It recognises that the state may want to use this expertise in the implementation period to build up the necessary skills within the NHI Fund. However, it adds, the government will then use this 'in-house capacity…rather than outsource any component [of the Fund's activities] to a private entity'. [Para 404, White Paper]

Restricting medical schemes to providing complementary cover is likely to sound their death knell. If a medical scheme undertakes to cover a rare disease (such as haemophilia), which is unlikely to be included in the NHI package, the pool of potential members wanting such cover will be very small. Premiums will therefore be so high that only the very rich will be able to afford them. [Serfontein, FMF presentation, 20 April 2016] Few, if any, medical schemes will survive.

Soon after the White Paper came out, Dr Motsoaledi seemed to distance himself from the White Paper's clear statement that medical schemes would be limited to 'complementary' cover. In an interview with *Business Day* in late January 2016, the minister said: 'We are not envisaging burning medical schemes outright. The private schemes like Discovery, we don't think it will be fair for any one of us to say they are no longer going to work. We want people to make their own choice.' He reiterated that no one would be allowed to bow out of making the mandatory prepayments, but stressed that people would still be allowed 'to do something privately'. The White Paper had given the wrong impression, he suggested, and this aspect of the document would have to be 'clarified and sharpened'. [Business Day 1 February 2016]

However, in an address to the Competition Commission's Health Market Inquiry in March 2016, the minister denied that he had distanced himself from this proposal in the White Paper. When the NHI was fully functional, he said, he 'wouldn't know any justification' for GEMS and other medical schemes to continue to exist. [*Saturday Star* 19 March 2016]

The White Paper also speaks of re-directing the state's contributions to GEMS and other government medical schemes to the NHI Fund, and of ending the tax credit currently allowed for medical scheme contributions (see above). But Basil Manuel, chairman of the Independent Labour Caucus, which represents 45% of public service employees, says his union has fought long and hard for the medical aid coverage the state helps provide and 'we

are not going to roll over and play dead. We will not stand by and see these benefits reduced.' [*Saturday Star* 19 March 2016]

Adds Jonathan Broomberg, chief executive of Discovery Health: 'We agree with the view that, once they have paid their mandatory NHI contributions, members of the public should retain the freedom of choice to purchase private health insurance. This is the practice in virtually every system of NHI across the world… It would also benefit the system as a whole by reducing the NHI's service delivery burden.' [*Business Day* 1 February 2016]

Compelling the participation of private practitioners

If medical schemes are confined to providing 'complementary' services and largely collapse as a result, few South Africans will be able to afford the high costs of private healthcare. This in itself will put great pressure on private practitioners to participate in the NHI, even though the capitation fee envisaged – which will be the same in both the public and the private sectors – is unlikely to cover the many overhead costs of maintaining a private practice.

However, the participation of private practitioners can also be assured in another way: by bringing into operation a chapter in the National Health Act of 2003 which already requires a 'certificate of need' for the provision of 'prescribed health services', the establishment of any new 'health establishment', and the 'continued operation of any health establishment'. Once these provisions are made operative, all private doctors, specialists, and other health care professionals will require a certificate of need from the government to establish or maintain their practices. So too will all present, and prospective, private hospitals and clinics. [Jeffery, *Chasing the Rainbow*, pp77-78]

The director general of health (and his staff) will be responsible for deciding on whether a certificate of need should be granted. This decision will depend, among other things, on the need to 'promote an equitable distribution…of health services' and 'correct inequities based on racial,…economic, and geographical factors'. It must also be governed by 'the epidemiological characteristics of the population to be served'. These factors are so vague as to give the director general and his officials a large measure of discretion in applying them. 'Since there will be no objective way to decide these issues, decisions will ultimately be based on ideological and political expediency,' writes the Free Market Foundation. Moreover, any appeal against the director general's decision will lie solely to the minister of health, rather than to the courts. [Jeffery, Chasing the Rainbow, pp78-79]

In 2014 the government gazetted a notice bringing the certificate-of-need provisions into operation and so requiring all health establishments – from general practitioners (GPs) to private hospitals – to obtain such certificates. However, it then transpired that necessary regulations setting out the criteria and processes for the granting of these certificates had not yet been gazetted. This meant that all existing private doctors and hospitals were automatically criminalised, as none had the required certificate. President Jacob Zuma was thus compelled to ask the Constitutional Court to set aside his proclamation bringing the relevant provisions into operation. The court obliged in January 2015, ruling that the

president's decision to sign the proclamation had been 'irrational and invalid' in the particular circumstances. This, however, said the court, was because the president had been 'led astray by his advisers' mistaken counsel'. [*Business Day* 29 January 2015]

Business Day commented that the government needed to avoid such mistakes in the future by appointing people for their competence rather than their political loyalty to the ANC. It also criticised the very concept of a certificate of need, saying: 'This is clearly an attempt by the government to get the private sector to compensate for its own failings. The aim of the certificate is to force doctors and hospital groups to set up shop in areas that are under-serviced by the state, rather than where they believe they will find the most patients who are able to pay for treatment... Given a choice between establishing a facility that will not be commercially viable and either investing elsewhere or emigrating, you do not have to be a brain surgeon to work out which way things will go.' [*Business Day* 29 January 2015]

Dr Motsoaledi made it plain that he planned to press on with the certificate-of-need provisions, which he said were 'part of the National Health Insurance white paper'. The new rules were needed, he went on, to encourage doctors and private hospitals to open practices in under-served areas such as townships and rural areas. Hence, the fact that the provisions had been withdrawn did not mean that they had been scrapped. Said Dr Motsoaledi: 'You will need a certificate of need to practise and we are going ahead with it. The reason we withdrew it was because it was badly written. I don't understand why people are seeing it as a monster.' [*City Press* 27 September 2015]

The White Paper in fact makes no reference to the certificate of need. It remains, however, a potent weapon in the hands of the health department to compel participation in the NHI. However, the practical outcome may be different from what the state envisages. Instead of signing up for the NHI, many doctors, specialists and health professionals may instead choose to emigrate. This will reduce the health care services available just as the NHI hugely increases the demand for them.

Ramifications of the NHI system

Problems in public health care remain unresolved

The White Paper barely acknowledges the many problems in the public healthcare system. It also lacks any realistic proposals to overcome the shortage of health care providers, improve the management of health care facilities, ensure a more effective use of tax revenues, improve dismal compliance levels with OHSC norms and standards, or put an end to the medical negligence that has caused so many unnecessary deaths and so greatly marred the lives of thousands of South Africans.

In 2011, when the green paper on the NHI came out, the *Financial Mail* warned that the NHI was likely to become 'another costly white elephant'. It added: 'We do not need a new health system. We already have an extensive state-funded network of clinics and hospitals, supported by medical schools that are generally world-class. The public system is, in principle, available to everybody, but it has a reputation for being so badly managed and

poorly resourced that anyone who can afford to pay medical aid fees chooses to buy the private services that are available. It is the unemployed and the poor who have no choice but to use public facilities.

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

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

'The NHI is misguided. Like many of government's grand schemes that have sought to divert attention from basic intractable realties, it has not been properly thought through. South Africa cannot afford it and it will end in tears – after doing a lot of damage along the way.' [*Financial Mail* 19 Aug 2011]

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

A huge increase in demand without enhancing supply

Experience all around the world shows that making health services 'free' at the point of supply hugely increases demand, while South Africa's own experience to date also bears this out.

In 1994, one of the ANC government's first initiatives was to entitle pregnant women and children under six to free services at public hospitals. This intervention, announced by President Nelson Mandela soon after his inauguration, was in line with the Freedom Charter's call for 'free medical care and hospitalisation' for all, 'with special care for mothers and young children'. However, it also brought an immediate increase in demand. Hospitals and clinics were flooded with new patients without a corresponding increase in the resources available to treat them, raising questions as to the quality of care being made available. [*Freedom Charter*, 1955; Jeffery, *Chasing the Rainbow*, p341]

This problem will be far worse under the NHI. Some 55 million South Africans will be promised 'free' health care at every public and private health establishment. But the number of doctors, specialists, and other practitioners working for the state will not increase by anything like the numbers required to meet this huge surge in demand. The White Paper has few ideas on how the number of health care professionals can be increased, simply saying that medical schools will 'be supported to increase their intake of students', that more scholarships will be provided, and the Cuban training programme – which has many weaknesses – will be expanded.) [Para 227, White Paper]

In addition, unless public health care facilities can be drastically improved, 84% of them will be unable to satisfy the OHSC that they are eligible for accreditation. [*Business Day* 24 May 2016] This will greatly diminish the public health care services available.

At the same time, many health care professionals now practising in the private sector may be unable to obtain a certificate of need in an area that suits them. Others may be unwilling to work for the unrealistic capitation fees envisaged. Many may choose to emigrate, rather than join the NHI. So demand will go up, but supply will not.

With health services diminishing, some basis for rationing their supply will have to be found. Under the NHI, health services will no longer be rationed by cost, but they will certainly be rationed by the time that people will have to wait to receive them. In Canada, which has a universal health care system similar in some ways to what the NHI envisages, waiting times have gone up significantly. According to a study conducted by the Fraser Institute in 2014, waiting times for medically necessary treatment have increased from 9.3 weeks in 1993 to 18.2 weeks in 2014. Especially long wait times were experienced for hip, knee and back surgery (42.2 weeks) or neurosurgery (31.2 weeks). [*The Star* 4 February 2016]

Yet Canada is far better resourced than this country. For seriously ill South Africans, the delays could literally be fatal. In other cases, where urgent treatment is necessary, patients' health is likely to deteriorate and recovery will then take longer. The thousands of people currently who currently have to wait years for cataract surgery, for example, will find that they have to wait even longer – and some could go blind in the interim. Overall, South Africans will be worse off under the NHI than they are now.

In addition, South Africa's economy is so weak that it will not be possible to generate the additional tax revenues needed for all the NHI services the White Paper now envisages. In practice, a much shorter list of benefits will be all that is affordable. At the same time, the private health care system will be so badly mauled that it will be unable to make up for what the NHI does not in fact provide. Again, people will be left off worse off than they are now.

A huge administrative burden

The NHI Fund will effectively be a huge, single-payer medical scheme with 25 times as many members as Discovery. It will also be administered by a government with a poor

reputation for competent and clean administration. To understand the magnitude of what is involved, it is useful to consider the experience of the Compensation Fund, which is the closest existing equivalent to the NHI Fund. The Compensation Fund receives the mandatory 'workmen's compensation fees', which many employers and their staff are obliged to pay. From these monies, it pays out compensation to employees who are injured at work. It also pays the medical fees of the doctors and specialists responsible for providing health care to employees injured in these circumstances. The fund records about R8bn a year in income and has R52bn in assets.

Between 2012 and 2015, the Compensation Fund paid out claims of between R1.4bn and R2bn a year. It often fails to pay out in time: so much so that in April 2015 (in answer to a parliamentary question) the director-general of labour acknowledged that the fund had yet to pay out on 231 000 outstanding claims with an overall value of R23bn. Some of these claims dated back as much as ten years. The director general added that the fund now planned to clear the backlog within two months, but this was clearly beyond its capacity to achieve. [*Business Day* 24 May 2016]

So bad is the situation that unpaid claimants have had to resort to litigation to compel the fund to pay what is owing to them. In July 2009, for example, Compsol, a company that handles claims against the fund on behalf of doctors, obtained a High Court order instructing the commissioner of the fund to pay out all claims which had already been validated within 75 days and to assess a backlog of remaining claims. However, this was not done, obliging Compsol to seek further judicial relief. In April 2016 the Supreme Court of Appeal (SCA) found the commissioner, Shadrack Mkhonto, in contempt of court for failing to comply with the 2009 High Court ruling. The SCA thus sentenced him to three months in prison, suspended for five years. How much difference this will make also remains to be seen. Moreover, it is not only the claims submitted by doctors that have remained unpaid for many years, but also those of employees injured at work and entitled to compensation from the fund. Persistent non-payment has resulted in hospitals turning Compensation Fund patients away. [*Business Day* 19 May 2015, 21 April 2016; *Legalbrief* 21 April 2016]

The implications for the NHI Fund are profound. Says Dr Johann Serfontein of the HealthMan consultancy: 'The Compensation Fund employs 1 630 people, who paid out R1.4bn in medical claims in 2015. By comparison, Discovery Health, with five times this number of employees, paid out 26 times the amount in medical claims. The required NHI budget is estimated at R256bn a year, which is 32 times larger than the size of the Compensation Fund's annual income of R8bn. The number of claims payable is likely to be 100 times more, not including the payment of suppliers. Using the Compensation Fund efficiency as a barometer, it would require the NHI Fund to employ between 52 000 and 106 000 people, more than the 90 000 members in the South African military. An army of people to run one health care fund.' [*Business Day* 24 May 2016]

This army of bureaucrats is unlikely to be any more efficient than those working for the Compensation Fund. In addition, it is most unlikely that the officials required can even be

appointed, for the Treasury has already imposed a moratorium on the recruitment of new public servants in an attempt to bring down public debt and reduce the budget deficit. This moratorium will make it impossible to appoint anything like the 52 000 officials minimally required to run the NHI Fund.

In these circumstances, long delays in the making of payments to health providers will inevitably follow. So too will long delays in paying for medicines and other essential medical equipment and consumables. The suppliers of pharmaceuticals and other such essentials will soon confront the same crises the NHLS has experienced for many years. Health care services will crumble further at all public facilities, while private ones will battle to maintain their existing standards. All South Africans will, again, be left worse off than before.

Proponents of the NHI are silent about the size of the bureaucracy required, how much it will cost, and how inefficient it might be. Instead, they simplistically claim that the NHI will help to bring down costs and will be much cheaper than the current system, the costs of which they constantly castigate. However, as a world-renowned public intellectual, Professor Thomas Sowell of Stanford University, has observed: 'It is amazing that people who think we cannot afford doctors, hospitals, and medication somehow think that we can afford doctors, hospitals, and medication – and a government bureaucracy.' [*Business Day* 20 January 2016]

Rigidities in treatment protocols

Already doctors and specialists complain that the treatment formularies drawn up by medical schemes are too inflexible, leaving them too little scope to provide the treatments best suited to particular patients. This problem will be far worse when bureaucrats set national treatment protocols under the NHI system.

Current rigidities have been highlighted in some of the submissions made to the Competition Commission's Health Market Inquiry. Specialist physician Dr Jeff King, for instance, said that many of his patients required medicines that were not included on their schemes' formularies – which had been drawn up by non-experts with a vested interest in minimising costs, rather than in maximising therapeutic outcomes. [*The Times* 11 February 2016]

Cardiologist Dr David Kettles added that he and his colleagues often found themselves fighting their patients' medical schemes in an effort to get them to pay for their health care. The doctor, who runs his own practice, said he frequently found himself sending requests to medical schemes that read as follows: 'Please sir, I promise you a pacemaker is really necessary", and 'You need an anaesthetic to do a bypass operation'. Because of medical schemes' resistance to funding more expensive medication, patients often ended up paying more for drugs or having to accept ones that were inferior. Necessary procedures were often delayed by repeated requests for cardiologists to motivate why their patients needed a particular operation or medication. Dr Kettles said that because of these constant back-and-forth questions, which seemed like a deliberate delaying tactic on the part of the medical schemes, 'patients suffered irreversible harm, and sometimes death'. [*Business Day* 19 February 2016]

Rigidities and delays will be far worse under the NHI, which will be laying down and enforcing treatment protocols, deciding on permissible blood tests, and raising questions about the need for millions of health procedures right across the country.

Unwieldy and unaffordable

South Africa cannot afford the proposed NHI. There are simply too many factors against it: from the failing economy and the small tax base to the increasing burden of disease, the ageing population, the poor performance of the public health care system, the limited number of health care professionals, and the huge increase in demand that will inevitably follow its promise of 'free' health care. [*Sunday Times* 2 August 2015] The NHI will simply raise expectations that cannot be met, while resulting in worse health care services for all.

Introducing the NHI will also exacerbate the country's economic plight, and increase the likelihood of successive credit ratings downgrades. These in turn could see the economy shrink even further, beyond the contraction of 0.3% of GDP already likely in 2016. A shrinking economy will further reduce the value of the rand, while pushing up inflation and triggering a million or more job losses. The possibility of the NHI resulting in more ratings downgrades is also not an idle one, for ratings agencies have specifically flagged the NHI as a key concern. In addition, the increased tax revenues needed for the NHI are simply unattainable, which means the government's debt burden could increase significantly in an attempt to fund it. This could tip South Africa into a debt trap from which there would be no easy escape. [*Business Report* 29 May, *Financial Mail* 26 February 2016]

The NHI, in short, is no solution to the health challenges the country faces. The ANC's insistence on it is not based on a rational assessment of present problems and how best to overcome them. Instead, it is based mainly on an ideological hostility to the private sector, coupled with an ideological determination to increase dependency on the state.

Ideological hostility to the private sector

The ruling party has long demonstrated a deep and ideologically driven suspicion of the private health care sector and the profit motive behind it. It also takes the view (as Dr Manto Tshabalala-Msimang, minister of health in both Mbeki administrations, once put it) that the private health care system is little more than 'a ravenous monster that preys on our people'. In 2004 Dr Kgosi Letlape, president of the South African Medical Association, said that the government's underlying agenda was to 'get rid of the private sector' in health care. Behind this objective, he added, lay the health department's philosophy that, 'If you can't treat everybody, you treat nobody'. [Jeffery, *Chasing the Rainbow*, p340]

Dr Motsoaledi has long been utterly (but unjustifiably) determined to bring down prices in the private health care sector, which he repeatedly accuses of profiteering and extortion. In 2011, for instance, he lashed out at the private health care system, blaming it for poor health care outcomes and saying it was 'unsustainable and destructive'. He was particularly scathing about private hospitals, saying they 'extorted money' from medical schemes and their

members. They also raised the cost of health care 'arbitrarily and unfairly'. Hence, he said, his best advice to anyone who yearned to be a billionaire was 'not to own a mine but a private hospital'. [*Saturday Star* 23 July 2011]

The minister has also repeatedly stressed the large differences between the fees charged by private and public hospitals. In July 2011, for example, he said that patients had to pay between R6 000 and R15 000 for a medical circumcision at a private hospital, when the same procedure cost R400 at public hospitals. But a source from the private hospital industry countered that 'the arguments and numbers' used by the minister were wrong. 'To compare public to private health is like comparing apples and oranges… The dominant source of public hospital revenue is a budget from government. Prices there do not reflect the true costs of running a sustainable hospital. The government also gets significant discounts on medicines, on average said to be some 50% to 70% less. The government never has to borrow money, and it doesn't pay VAT. [This is why] the public sector can present what seems to be a lower-cost model.' [*The Citizen*, *The Times* 4 July, *Saturday Star* 23 July 2011]

The Hospital Association of South Africa (Hasa), which represents more than 80% of private hospitals, added that the fee of R15 000 which Motsaoledi had quoted for a circumcision at a private hospital was 'probably…an isolated billing case which should not be used to taint the private sector'. Hasa chairman Nkaki Matlala said it was also 'deceptive' to compare rates charged for circumcisions in private hospitals to fees in the public sector because such comparisons did not take into account 'the significant differences in the standard of care provided in the private sector'. [*The New Age* 3 July, *The Citizen*, *The Times* 4 July 2011]

Also in 2011, the minister blamed the private sector for 'a predatory health care system where the sick and the vulnerable are the ones who get attacked.' In 2012, while acknowledging that public hospitals were in a parlous state, he added that a large part of the public sector's problems stemmed from 'rampant commercialisation in medicine'. This constantly led to ever-rising prices, which reduced the number of people able to afford private care and increased the burden on the public sector. He blamed rapid increases in private hospitals on the 'over-provision' of medical services, along with unethical practices such as over-charging for surgical supplies and materials. He also poured scorn on the suggestion that prices were rising because medical scheme members were getting older and needing more expensive treatment. Instead, as *Business Day* commented in an editorial, he continued to claim that the main cause of soaring medical inflation was 'private-sector greed'. [*The Times* 5 July 2011, *Business Day* 11 September 2012]

When proposals for the NHI system were first set out in a 200-page discussion document published by the ANC in 2009, Dr Blade Nzimande, general secretary of the South African Communist Party (SACP) went so far as to threaten 'war' against anyone who opposed it. Said Dr Nzimande: 'The capitalist classes have already started a huge campaign in the media to try to discredit this system and we want to say to them as communists today, war unto you.' He vowed that workers would 'meet capitalists in the streets' and warned them to 'prepare for a huge battle because we are going to mobilise the workers and the poor of the

country to fight against you'. He also promised that, under the new system, the rich would pay more and the poor would pay nothing and 'everybody will get the same quality treatment'. [*Business Day* 11 August 2009] However, such ideological outbursts are hardly helpful to any considered attempt to resolve the health care challenges confronting the country.

Since then, Dr Motsoaledi and others in the tripartite alliance have repeatedly stressed that the government must be the key provider of health care in the country. This, they claim, is because health care is 'a public good and not just any commodity'. This perspective is also reflected in the White Paper, which stresses that health care 'must not be treated as a commodity, but as a social good'. Cosatu also emphasises that 'health care is a social right and not a privilege'. [*Business Day* 19 March 2013, *The Times* 14 December 2015, Cosatu, 'Release of NHI white paper a watershed moment', 14 December 2015] That the private sector is in fact far more effective at providing health care – and could greatly help the public system improve its often flawed operation – is simply ignored.

Cosatu has warned that it too is 'gearing up for a fight with the middle classes' if they oppose the NHI and try to stop it. Said Mike Shingange, first deputy president of the National Education, Health and Allied Workers' Union (Nehawu) in January 2016: 'We don't believe in medical aids, just like we don't believe in private hospitals.' He reiterated that health care is a 'human right' and cannot be provided by 'a business for profit'. Dr Motsoaledi seems to agree, describing 'the existence of medical schemes as a punishment for poor people'. (However, the minister seems keen to access the reserves that medical schemes have built up over the years and which now amount to some R43 billion, even though these monies rightfully belong to the members of these medical schemes.) [*The Times* 26 January 2016, *The Citizen* 12 December 2015, 11 May 2016]

Driven largely, it seems, by his ideological hostility to the private sector, Dr Motsoaledi is determined to implement the NHI, even though this will require what he himself describes as 'drastic' and 'massive legislative and structural alterations to private and public healthcare systems'. [*The Citizen* 11 May 2016] Yet this kind of massive reorganisation, especially at the hands of an inept and often corrupt administration, is likely to destroy far more than it creates. It will, however, build a massive dependency on the state, which will have sole authority over the availability of medicines and all other medical supplies, the treatment protocols to be applied, the diagnostic blood tests that may be permitted, the areas where private health care professionals may practise, the fees to be paid to all practitioners, and (given lengthy waiting times) the key question of who is to be given access to health care and who is not.

The NHI is clearly intended to give effect to the Freedom Charter, which was drawn up in 1955 (more than 60 years ago) with significant communist input. The charter says that 'a preventive health scheme shall be run by the state', and that 'free medical care and hospitalisation shall be provided for all, with special care for mothers and young children'. The SACP, which has long had great influence over the ANC, sees the full implementation of

the charter as a vital step in taking South Africa to a socialist and then a communist future. This helps explain why the party is so hostile to the idea that the private health care sector could help provide the 'preventive' and 'free' health care called for in the charter. This also helps explain why the White Paper now effectively sounds the death knell for private health care in South Africa. However, the SACP has no mandate from the people of South Africa for the communist future it is actively trying, with the help of the ANC, to bring about.

There are also many better ways than the NHI in which the health needs of all South Africans could be met. Moreover, though the World Health Organisation does indeed stress the need for 'universal health coverage', as Dr Motsoaledi has often pointed out, the organisation also stresses that this objective can be achieved in a variety of ways. In South Africa, there are many alternative solutions available. These would also provide all South Africans with quality health care on a far more effective, efficient, and sustainable basis than the NHI system can do.

Alternatives to the NHI

The White Paper rightly criticises the fact that only 16% of South Africans belong to medical schemes. However, there are many ways in which the costs of having medical aid could be reduced and coverage extended.

The first step is to revive the government's earlier proposals for social health insurance (SHI). These were partially implemented but then abandoned (after the ANC's Polokwane conference in 2007). Yet partial implementation has done much to hamstring the medical scheme sector – and this needs to be rectified.

The SHI requirements of open enrolment and community rating have been introduced (as earlier described), but the government has yet to act on its earlier promise of mandatory medical scheme membership for all employed people. Voluntary enrolment has given rise to 'adverse selection', whereby people join medical schemes only when they are sick, or anticipate a major medical event, such as childbirth. This means that there are fewer young and healthy members to subsidise those who are ill. This lack of mandatory enrolment adds an estimated extra 15% to premiums, as Barry Childs, joint chief executive of Insight Actuaries and Consultants, told the Health Market Inquiry in March 2016. 'That is R20bn per annum. You can pay a lot of GPs with that money.' [*Business Day* 22 March 2016] Mandatory enrolment (coupled with rules that would allow people to choose between medical schemes, health insurance, or both) would help overcome the problem of adverse selection. It would thus bring down the costs of both medical schemes and health insurance and make both far more affordable.

As part of the SHI concept, the government also earlier promised to introduce a 'risk equalisation fund' between different medical schemes. Via this fund, schemes with higher numbers of younger and healthier members would contribute to schemes with higher numbers of older and sicker ones. This would allow medical schemes to compete on

efficiency, rather than their ability to attract low-risk members. [*Business Day* 22 March 2016] Hence, the introduction of a risk equalisation fund must also now be re-considered.

One of the most pressing problems is that the costs of medical scheme membership have been greatly increased by the government's insistence that all schemes must 'pay in full' for almost 300 prescribed medical benefits (PMBs). The Department of Health has also failed to review these PMBs every two years, as required by the Medical Schemes Act. [*Business Day* 22 March 2016] The government is pricing medical aid beyond the reach of most South Africans through its insistence on comprehensive PMB cover that most people do not require and do not want. It should withdraw this requirement and allow South Africans a choice between medical schemes that cover PMBs and schemes that do not. Where people opt for the second and cheaper option, they should be allowed to protect themselves against unexpected and major health care costs by taking out appropriate medical insurance policies.

The Council for Medical Schemes should also revive its 2015 proposal for a 'low-cost' medical scheme which provides limited, but important, benefits to low-income households. These would not provide cover for PMBs, but they would nevertheless give people access to a number of specified benefits – to be provided by private practitioners at the primary care level – against monthly premiums starting at around R180 per adult member per month. As the council has acknowledged, this in itself could make medical scheme coverage available to another 15 million South Africans. [*Business Day* 29 July,15 October 2015, *Saturday Star* 1 August 2015] Though these members would have to rely on public hospitals, the fact that 15 million people would be meeting most of their needs for primary health care from the private sector, rather than the public one, would in itself greatly alleviate the pressure on state facilities.

In addition, the government should welcome rather than seek to prohibit the 'combination' health insurance policies that give people both hospital cover and a range of primary health care services, to be obtained from the private sector rather than the state. Research commissioned by the Centre for Financial Inclusion and Regulation (Cenfri), on behalf of the FinMark Trust, and made public in April 2016, demonstrates the many advantages that lie in this approach.

According to the researchers, the government should 'permit the sale of affordable health insurance products' as this offers an important way for low-income households to access private health care. Most South Africans, they note, earn less than R5 000 a month and cannot afford medical scheme membership (though this problem would, of course, be much reduced if the government were to allow the low-cost option mooted last year). However, medical insurance can be made much more affordable by the discounts of up to 50% that insurance schemes commonly provide where policies are sold to large groups (as this helps spread the risk). In addition, many employers may be willing to help pay the costs of medical insurance premiums, which would also make the insurance option more affordable to low-income households.

According to the researchers, a group discount of 40% would significantly reduce the premiums normally payable by a household earning around R6 250 a month. Premiums then would come down to 6% of disposable income for a hospital-only plan, to 7% for day-to-day cover, to 8% for day-to-day cover plus limited hospital cover, and to 13% for day-to-day cover plus comprehensive hospital cover. If an employer subsidy of 50% is also factored in, premiums would fall to 3% for a hospital plan and for day-to-day cover, to 4% for day-to-day cover and a limited hospital plan, and to 6% for day-to-day cover plus hospital cover. These percentages would be very affordable for all medical insurance products – especially as the standard rule of thumb is that medical cover should not exceed 10% of a household's disposable income. [*Saturday Star* 16 April 2016]

The R173bn in tax revenues currently allocated to the public health care system could also be far better used through improved management and increased efficiencies. These gains could best be achieved through effective public-private partnerships. Private firms should be allowed to compete, on price and functionality alone, for contracts to run public facilities within the parameters laid down by the Department of Health.

According to Morgan Chetty, chairman of the Independent Practitioners Association Foundation (which represents doctors), 'the government seems to see the private sector as a threat', but in fact it offers the best way of turning the struggling public system around. Says Dr Chetty: 'Public-private partnerships have the potential to combine the best attributes of both sectors.' Under such a system, the government would be responsible for setting appropriate parameters, while the private sector would be responsible for effective and cost-efficient delivery. 'Ideologists think government has all the solutions and should implement the NHI. But pragmatists see a public-private solution.' Moreover, this approach could quickly bring about major improvements, whereas the NHI will take many years to implement. [*Business Day* 26 May 2016]

The government should also remove the regulations which currently prevent private training for doctors and restrict private training for nurses. It should encourage the establishment of more private hospitals and clinics, especially day-hospitals with their lower costs. It should allow hospitals to employ doctors and specialists, so reducing the costs to these professionals of running their own practices. It should remove the rules that prevent pharmaceutical companies from offering discounts for bulk orders of medicines in the private sector. It should also scrap the 'single exit price' regimen which has seen many pharmaceutical manufacturers exiting the country because permitted price increases are too low to cover mounting costs (especially as the rand weakens and imported ingredients become much more costly). It should strengthen the Medicines Control Council (and the South African Health Products Regulatory Authority which is expected to replace the council next year) and ensure that approvals for new medicines are quickly granted. The certificate-of-need provisions should be scrapped.

The government should also encourage innovation and a greater use of technology wherever this can help reduce costs. To name but one example, consultations via smart phones with

doctor and specialists would be easier if high-speed broadband were more uniformly available. It should encourage the establishment of day hospitals, where many procedures can be carried out at lower cost. (In the US, some 63.5% of all surgical procedures are now carried out at such hospitals, but South Africa as yet has only around 50 of these institutions while every new one currently requires express government approval.) [*The Times* 26 May 2016*, Business Day* 23 July 2015] Instead of threatening patent rights, the government should encourage the inventors of new medicines and new medical equipment and devices to stay inside the country by respecting and upholding their intellectual property rights.

The government should also increase the affordability of medical aid cover and health insurance by introducing state-funded healthcare vouchers for households earning less than R15 000 a month. The current medical aid tax credit could be combined with a portion of current provincial health expenditure to yield significant amounts of annual revenue. This could be used to provide every household within this income range with a voucher which could be used solely for the purchase of health care services from either the public or the private sectors.

Combined with the reforms earlier outlined, this would ensure that every household would be able to gain access to a medical scheme. It would also allow them to top up their cover by buying medical insurance for conditions not covered by their medical aids. Universal coverage would then be assured, while private sector efficiencies would help to keep costs down and performance standards up. This would be a far better option than destroying the private sector, as the NHI envisages. It would also give public facilities important reasons to improve their performance, so that they could compete effectively for households armed with health-care vouchers. It would also give public facilities an incentive to enter into the public-private partnerships that would be so effective in turning failing institutions around.

The introduction of health care vouchers, in combination with the other reforms proposed, would enable the country to build further on the many strengths of its existing health care system. This is far preferable to the NHI system, which will destroy the private health care sector and greatly weaken the capacity of the public system through the massive restructuring, unaffordable costs, bureaucratic bottlenecks, and massive unmet demand that it will usher in.

The pragmatic alternatives outlined here will also help the economy. Whereas the introduction of the NHI will trigger ratings downgrades, further restrict growth, weaken the rand, and add to the unemployment crisis, these practical reforms will provide a welcome signal that South Africa remains open for business.

Coupled with other policy reforms, this will help to stimulate investment, push up the growth rate, draw millions more people into jobs – and give all South Africans a realistic prospect of upward mobility and a better life overall.

Unconstitutionality of the NHI

Section 27 of the Constitution says that 'everyone has the right to have access to health care services, including reproductive health care'. It also obliges the state to 'take reasonable legislative and other measures, within its available resources, to achieve the progressive realisation of this right'. [Section 27(1)(a), (2), Constitution of the Republic of South Africa]

Proponents of the NHI say that this proposed system is essential to fulfil this right. This, however, is not so. The alternative solutions outlined here would be far more effective in giving all South Africans access to quality health care on a basis that everyone, helped by state-funded health vouchers, can afford.

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

The NHI idea is also inconsistent with other guaranteed rights. Forced participation in the NHI Fund contradicts the right to freedom of association in Section 18 of the Bill of Rights. Confining medical schemes to complementary services – and thereby preventing them from remaining in business – is inconsistent with the right to property in Section 25 of the Constitution. Barring health care professionals from private practice – as the certificate of need and all the state controls implicit in the NHI will do – is inconsistent with the right of every citizen 'freely…to choose their own profession' under Section 22 of the Bill of Rights.

Fortunately, however, it is not necessary for the government to breach the Constitution in order to achieve universal health coverage and high standards of health care for all. The reforms that will be effective in achieving these goals have also been outlined. All that is needed is the political will to adopt them.

South African Institute of Race Relations NPC **31st May 2016**