President Zuma's NEC win – and what it might mean for survival of private healthcare sector

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The ANC's National Executive Council meeting has come and gone. There was plenty of excitement given the extra day, and murmurs of an internal bust up, as three ministers called on President Jacob Zuma to resign. And while these calls fell on deaf ears, it will be business as usual for Zuma, albeit he may be sleeping with his eyes open these days. The daggers are well and truly out, but what will become of those who made a stand? One in particular interests Anthea Jeffery, Health Minister Aaron Motsoaledi. Motsoaledi was a key driver behind the proposed National Health Insurance scheme, which could need funding of R790bn a year by 2025. But given his loss to Zuma, one must wonder if he will resign, or be pushed. And if he does go, and his replacement is not as ideologically committed to the NHI, Jeffery says it might turn out to be one of the positive outcomes of the NEC's failure to compel Zuma to stand down. – Stuart Lowman

Will the effective nationalisation of the private health care sector under the proposed National Health Insurance (NHI) system be placed on hold now that health minister Dr Aaron Motsoaledi has publicly clashed with President Jacob Zuma at the recent three-day meeting of the ANC's national executive committee (NEC) and lost?

Most South Africans are well aware of the benefits the proposed NHI is supposed to bring: free, quality health services for all 55 million South Africans, based on their medical needs rather than their capacity to pay.

Many may also be aware of what the NHI will supposedly cost when it's made operative in 2025 – R256bn in its first year, according to the White Paper put out in December 2015.

Some people may also realise that a more realistic projection, based on the cost of extending some 300 prescribed minimum benefits (PMBs) to all South Africans, would put NHI spending at R400bn in today's terms. (However, since spending on health care has grown by 9% a year on average since 2011, the NHI funding need could be R790bn a year by 2025.)

However, few people seem to realise that a crucial aim of the NHI is effectively to nationalise the country's world-class system of private health care – to which millions of black South Africans have finally been able to gain access via rising incomes and membership of medical schemes.

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

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

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

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

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

The imposition of these controls will amount to a regulatory expropriation. Yet no compensation will be payable for expropriation of this kind under the Expropriation Bill of 2015. This Bill was adopted by Parliament in May 2016 and needs only Mr Zuma's assent to be enacted into law. However, so flawed was the procedure used in its adoption by the National Council of Provinces that Mr Zuma has questioned this process and delayed signing the Bill.

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

Whether the Bill's definition of expropriation is in keeping with the Constitution is doubtful. There is nevertheless a significant risk that the Constitutional Court will uphold it as valid.

All private medical practices will face essentially the same situation as the private hospitals. The state will not 'acquire' them, but the private GPs and other health professionals who own them will

generally lose their capacity to run them at a profit. They will also lose much of their professional capacity to treat patients as they think best, to which many may object.

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

Important too are the long delays that are likely to arise before the NHI Fund pays the fees due to hospitals, specialists, GPs, and others for the health services they have already provided free of charge. If experience with the statutory Compensation Fund (which pays doctors who treat employees injured at work) is taken as a guide, delays of 70 days or more could be the norm. Payment delays of ten years or more could also be encountered.

Few private hospitals or private practices are likely to survive these heavy blows. Many specialists and other practitioners could also decide to emigrate. So too could much of the middle class, whose skills and buying power are vital to the economy.

The real purpose of the NHI is not to help the poor gain access to better health services. Rather, it is to advance the ANC's national democratic revolution (NDR), with its socialist and communist objectives, by pushing private providers out of the health care sector and putting the state solely in charge. This will deepen dependency on the government, while crippling a vital part of the market economy.

Since the Left propelled Mr Zuma into power as South Africa's president in May 2009, Dr Motsoaledi has been pushing hard for the NHI to be introduced. He is also part of the leftist group – now worried about the ANC's electoral prospects – that confronted the president at the NEC meeting and demanded that he step down.

Dr Motsoaledi and his fellow leftists in the cabinet have lost their fight with Mr Zuma. The health minister may now have little option but to resign, failing which he could in any event be reshuffled out of his post.

If Dr Motsoaledi goes, his replacement might just be less ideologically committed to the NHI and less determined to push it into place. This might be one positive outcome of the NEC's failure to compel Mr Zuma to stand down.

Much more will be needed, however, if the enormously damaging NHI proposal is to be defeated. The first imperative is for all South Africans to start looking beyond the false promise of the NHI to what the new system will truly bring about.

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