South African Private Practitioners' Forum

Submission on NHI Financing to the Davis Tax Committee

SAPPF
SOUTH AFRICAN PRIVATE PRACTITIONERS FORUM

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Executive Summary

The South African Private Practitioners' Forum (SAPPF) is of the opinion that the affordability of the NHI is definitely a core policy issue. One cannot ignore considering the costs involved, nor can we dismiss it as "the wrong approach", as stated in the NHI White Paper. Affordability of the NHI system in its current format, is questionable. This does not, however, mean that South African cannot afford Universal Healthcare (UHC). What is does imply, is that a different, more appropriate funding model needs to be considered. The low levels of employment and the small base of tax payers in South Africa compared to other countries using tax-funded public health systems is an indication that one needs to have higher levels of employment to sustain such a system.

Experience in countries such as Korea shows that UHC is difficult to fund, even with much larger tax bases and contribution percentages. Ireland has shown that timely costing of an NHI model is vital, to prevent unnecessary expenditure of effort and money on an unaffordable system.

The potential administration costs of a large, government administered, single payer NHI Fund appears to have gone unconsidered in the NHI White Paper. The costs involved with government administered funds of a similar nature (Road Accident Fund and the Compensation Fund) would indicate that private administration of the NHI fund would be the most cost effective option.

The potential decline in GDP with the reduction of private healthcare spend and the reduction in healthcare administration employment with the assumed reduction of private healthcare funders in the NHI White paper could have serious implication for the SA economy. The ownership of medical scheme reserve funds also needs to be ascertained.

SAPPF proposes an alternative UHC funding model, which will incorporate the following measures:

a) Introduction of Mandatory Low Income Medical Scheme (LIMS) cover for all Employees
b) Introduction of Mandatory Gap Cover for all employees
c) Introduction of a revised NHI Fund
d) Introduction of Public Private Health Partnership and private sector reforms
e) Some current White Paper proposals to be kept active

The nett additional Government costs of SAPPF's proposal, would be R4.9 billion, assuming a 100% tax credit on employers' LIMS contributions (and the corresponding R26.6 billion reduction in district health spending). Employers will spend an additional R7.4 billion annually on gap cover, while employees will receive comprehensive health cover for a R139.50 contribution per month.

Pre-Amble

1. The South African Private Practitioners Forum (SAPPF) is a voluntary association of private specialists working in the South African private health sector. The organisation has a membership base of approximately 2689 specialists representing most specialist disciplines. SAPPF acknowledges the transformative elements in the Constitution and the Constitution's commitment to improve access to health care. Furthermore, our humanity compels us to work towards quality universal access to health care for all of our citizens, within the constraints of resources in Government.
2. The National Department of Health (DOH) published the draft Policy (40th version) on National Health Insurance (NHI) under Government Notice 1230 in the Government Gazette 39506 on 11 December 2015 (the White Paper). Subsequently, the Davis Tax Commission invited interested persons to submit comments and representations on Funding of National Health Insurance, in a statement issued on 1 September 2016. It is pursuant to this invitation that these submissions are made. Although SAPPF is not an authority on tax or financing, it is important to address the most apparent shortcomings in the funding proposals as presented in the NHI White Paper.
3. We note the contents of the White Paper and welcome the opportunity to submit comments and participate in this nationally important debate, with the focus now shifted to funding of the NHI, by the Davis Tax Commission (DTC). The future of health care in this country is vital, not only to our membership and other participants in the health care industry, but to all South Africans. It is therefore with some disappointment that we take note of the lack of revision of the funding proposal between the White Paper and the original draft Green Paper, despite the indication in the White Paper that "Over 150 written submissions were received from interested individuals and organisations and were carefully reviewed and considered as part of the drafting of this White Paper. Inputs received from consultations with key stakeholders during national and provincial road-shows (which involved more than 60,000 people spanning over a period of four years) have also been taken into account. In addition, consultative meetings and workshops were held, some involving international experts." In particular, the Treasury costing models have not been updated in four years, despite the Minister of Health indicating in August 2015 that the treasury costing model has been completed and will be included in the White Paper[1,2]. We are conscious of the fact that both the public and private

[1] Benedict Ngwenya, East Coast Radio. "NHI finance document ready: Minister" https://www.ecr.co.za/news-sport/news/nhi-finance-document-ready-minister/

[2] Tamar Kahn, Business Day. "NHI chugs along, working to cut through the red tape" http://www.bdlive.co.za/national/health/2015/08/24/nhi-chugs-along-working-to-cut-through-the-red-tape

health care sectors face significant challenges and are in need of reform, and we intend to participate constructively in the debate as to how these challenges are best addressed. SAPPF supports a pragmatic approach to health care reform and believes that any proposal which seeks a radical overhaul of the health care system should be carefully considered and empirically researched prior to implementation. Any such proposal should also be subject to a comprehensive consultative process of engagement with all affected stakeholders.

4. We believe that NHI's impact on the economy, its likely cost and the details of the intended model must be substantively addressed by DOH in partnership with National Treasury and other role players. It is therefore pleasing that the White Paper was disseminated to the South African people for their consideration and detailed commentary. The implementation of far-reaching health care reforms will be costly and could have significant adverse consequences if not implemented successfully. It will also involve a significant commitment to- and from the South African people. Reforms should thus only be pursued if they are practically implementable and affordable. The failure to update its cost models in the four years between the original Green Paper and the finalisation of the White Paper is especially concerning, as Ireland recently had to scrap their Universal Health Insurance proposal due to cost models that were completed 4 years after the publication of their White Paper, indicating that the proposed model of Universal Health Insurance, was in fact not affordable for Ireland[3].

5. The NHI policy further promises "Free healthcare for all". The concern is, that although *receiving* healthcare would be free, *providing* healthcare is not and it would have to be funded by some form of taxation or contribution. South Africa has 5.7 million taxpayers who, in some of the proposed NHI funding scenarios, would potentially need to fund healthcare for 55 million South Africans, including the 8.8 million medical scheme members who are currently privately self-funding their healthcare.

6. SAPPF would like to positively contribute to the debate, by critically examining the funding proposals, and also proposing an alternative funding model to achieve Universal Healthcare in South Africa, at much lower costs than the current NHI proposals.

1. Expenditure Projections and Cost Estimates for NHI

7. Paragraph 249 and 250 of the NHI White Paper refers: Although the World Health Organisation (WHO) is alluded to in the White Paper as cautioning that while costing assumptions and scenarios may be useful for raising core policy issues regarding the sustainability of reforms, it is not useful to focus on getting the exact number indicating the

[3] Irish Times. "An outstanding policy failure on universal health insurance". 23 November 2015

estimated costs. The DOH then seems to dismiss focusing on the question of "what will NHI cost", insisting that it is better to frame the question around the implications of different scenarios for implementing reforms that will achieve universal health care (UHC). It is a concerning failing to assume that one does not need to do a costing of the NHI in order to implement it, as affordability cuts to the core of the implementation potential of the policy. The WHO clearly states that costing assumptions and scenarios may be useful for raising *core policy issues* regarding the sustainability of reforms.

2. NHI Expenditure Projections: Modified Costing from Green Paper

8. In its NHI cost projection (Paragraph 253), which reaches R256 billion in 2025/26, "*NHI expenditure increases by 6.7 per cent a year in real terms after 2015/16, resulting in a cost projection in 2025/26 of R256 billion in 2010 prices. These projections would take the level of public health spending from around 4 per cent of GDP currently to 6.2 per cent of GDP by 2025/26, assuming the economy grows at an annual rate of 3.5 per cent. This increase would be below the level of public spending (as a percentage of GDP) of many developed countries*." The South African GDP growth rate has been slashed to 0.1% for 2016 and to 1.0% for 2017 by the International Monetary Fund[4]. The GDP growth projection used for this NHI model is optimistic and has not been updated to reflect current realities.

9. The current low GDP growth estimates will lead to a much larger spending shortfall, which will need to be financed. The 2010 baseline costs used, only indicate the public health budget for 2010. The NHI system will combine both public and private patients in one system, yet the estimated cost projections only included figures for Government spend on public healthcare. As private spending was similar to public spending in 2010, the assumption by this model to only include government spend, would provide insufficient funds for the number of users of the system, despite the indication in the Green Paper that increased demand and utilisation was considered in the process. This poses questions as to whether this is the correct model to utilise. The model, using 2010 terms, also does not include the fact that the South African Rand has depreciated by 26% between 2010 and 2016 against the US dollar, which has a material influence on the cost of healthcare supply, where imported equipment and medicines are often utilised.

10. If one substitutes the actual 2015/16 Public Health spend into the table provided in the NHI White Paper (Table 1, Projected of NHI Costs adapted from the Green Paper) in 2016 currency, it creates the scenario illustrated in Table 2 of our submission. It can be seen by merely

[4] IMF. World Economic Outlook- Uncertainty in the Aftermath of the U.K. Referendum, July 2016.

updating the values of the projection to actual figures, without changing any other variables in the scenario, the White Paper cost projection escalates to R332 billion in 2025.

Table 1: White Paper projection of NHI costs adapted from Green Paper

	Average annual percent increase	**Cost Projection R m (2010 prices)**
Baseline Public Health Budget: **2010/11**		**109 769**
Projected NHI expenditure:		
2015/16	4.1%	134 324
2020/21	6.7%	185 370
2025/26	6.7%	**255 815**
Funding Shortfall in 2025/26 if baseline increases by:	2.0%	108 080
	3.5%	71 914
	5.0%	27 613

Table 2: Projection of NHI costs, Utilising 2016 values

	Average annual percent increase	**Cost Projection R m (2016 prices)**
Baseline Public Health Budget: **2010/11**		**113 088[1]**
Projected NHI expenditure:		
2015/16	7.9%[1]	173 587[1]
2020/21	6.7%[2]	240 070[3]
2025/26	6.7%[2]	**332 017[3]**
Funding Shortfall in 2025/26 if baseline increases by:	2.0%	184 282[4]
	3.5%	148 116[4]
	5.0%	103 815[4]

Notes: 1. Actual Expenditure in 2016 values
2. DOH White Paper Projections
3. Figures based on DOH Growth Projections and actual 2015/16 spend
4. Shortfall based on restated 2025/26 spend

3. Inclusion of the RAF and Compensation Fund

11. An important factor to take note of, is that the Road Accident Fund (RAF) and Compensation Fund will be incorporated into the NHI Fund. Paragraph 322 of the White paper states that "*NHI will be established as a single-payer and single-purchaser fund responsible for the pooling of funds and the purchasing of personal health services. The NHI Fund will be appropriately*

financed in order to be able to actively purchase personal health services for all who are entitled to benefit." Further to this paragraph 325 of the White Paper indicates that "*The NHI Fund will be publicly administered and established through legislation as an autonomous public entity*." The White Paper also specifies in paragraph 332 that "*Once fully implemented, the NHI fund will include medical benefits currently reimbursed through the Compensation Fund… and Road Accident Fund*." We will now examine the financial implications of including medical claims, liabilities and related reserves of the RAF and Compensation Fund into the NHI fund, as is alluded to in the NHI White Paper.

11.1 The Compensation Fund compensates workers and employers for injuries incurred in the line of duty and also provides for their medical expenses. The fund currently holds reserves of R 53.1 billion[5]. Solvency requirements for medical schemes under the Medical Schemes Act (Act 131 of 1998), requires that medical schemes have reserves equalling 25% of annual member contributions. Expressed in these current terms, the Compensation Fund would have a solvency rate of 637%. The fund currently has provisions of R3.26 billion for current outstanding claims and R7.3 billion provision for non-current claims. These provisions amount to 126% of annual received contributions. The Public Finance Management Act (Act 1 of 1999) determines that service providers need to be paid within 30 days of invoice and even though service providers have 12 months to submit claims, the R7.3 billion provision for non–current claims raises concerns about the efficiency of the Compensation Fund.

11.2 The RAF compensates victims of road accidents in South Africa and also covers their resultant medical expenses. The fund currently has R7.366 billion in reserves[6], which compared to medical scheme solvency requirements, would provide for a solvency rate of 32.5%. The fund has provision of R 34.4 billion for current outstanding claims and R82 billion for non-current claims. These provisions amount to 514.5% of contributions.

11.3 Table 3 illustrates projections of income, reserve and liability trends at the RAF and Compensation Fund from the 2014/15 to 2025. These were taken at the average of medical claims managed by the funds as a percentage of the total claims in the last 3 years. This medical claims liability percentage of the total claims was then projected forward to 2025. The same percentage of reserves and income was also projected forward to 2025. At the Compensation Fund, on average, 35.6% of all claim payments were for medical claims, while 5.4% of claim payments at RAF for was for Medical claims. If one projects the current income,

[5] Compensation Fund Annual Report 2014/15
[6] Road Accident Fund Annual Report 2014/15

reserve and liability trends of the RAF (at 5.4% of total claims paid) and Compensation fund (at 35.6% of total claims paid) forward to 2025, when the NHI Fund would be fully operational and assuming responsibility of these claims, it would create the following scenario for the NHI Fund: The NHI fund will start with reserves of R 55.9 billion, largely attributable to the Compensation Fund reserves. This will give the NHI fund a solvency ratio of 21.8% by the current medical scheme standards, if government's projected costs of R256 billion annually is used. If the projected costs from Table 2 are used (R332 billion), this reserve level drops to 16.8%. The NHI fund will, however, have outstanding medical claim liabilities of R30.2 billion, or 9.1% of annual contributions.

Table 3 – Projections on RAF and Compensation Fund Income, Medical Liabilities and Reserves

	2014	2015	2016	2017	2018	2019	2020	2021	2022	2023	2024	2025
RAF '000 000												
Income	1 095	1 221	1 347	1 473	1 599	1 725	1 851	1 978	2 104	2 230	2 356	2 482
Reserves	415	397	380	362	344	327	309	291	273	256	238	220
Outstanding Medical Claims	5 258	6 281	7 305	8 328	9 352	10 375	11 399	12 422	13 446	14 469	15493	16 516
COID '000 000												
Income	2 499	2 926	3 353	3 780	4 207	4 634	5 062	5 489	5 916	6 343	6 770	7 197
Reserves	15248	18927	22605	26284	29963	33641	37320	40999	44678	48356	52035	55714
Outstanding Medical Claims	2 760	3 755	4 750	5 745	6 740	7 735	8 730	9 725	10 720	11 715	12710	13 705

4. Administration costs of the NHI

12. The NHI White Paper is lacking in information regarding the potential costs involved with public administration of the NHI Fund and the number of state employees it might require for its administration. When one looks at possible scenarios for the costs involved with public administration of the NHI Fund, one could use the current efficiency levels of the Compensation Fund for comparison purposes. The Compensation Fund employs 1630 employees who pay out R4.1 billion[7] annually in claims. From the White Paper, it is clear that all government and private facilities will be contracted to provide services to the NHI as cost centres with their claims paid out of the single purchaser NHI fund. If the Compensation Fund claims paid are multiplied to the projected R256 billion budget of the NHI White Paper in 2025, it would require 101 775 Compensation Fund staff members to administer the NHI Fund. This does not account for any economies of scale, but these seem to be absent in the Compensation Fund as well, when compared to efficiencies of private medical scheme

[7] Compensation Fund Annual Report 2014/15

administrators. The current cost per staff member of the Compensation Fund is R273 000[8]. The administrative budget of the NHI Fund would thus amount to R 27.78 billion, using the current efficiency levels of the Compensation Fund. The Compensation Fund employees only paid 61% of all liabilities in the 2014/15 year, which would have negative implications for the administration of the NHI fund and the continued delivery of healthcare services if providers go unpaid.

13. On examination of the RAF, it employs 2555 employees, who paid out R 23 885 453 000[9] in claims last year. Taking the proposed NHI budget at R256 billion, it would require 27 384 RAF staff members to run the NHI Fund. Based on the monetary value of claims paid out, RAF staff are more efficient than Compensation Fund staff. It is also indicated in the RAF annual report[8] that RAF staff are, on average, remunerated at higher levels than Compensation Fund employees. The cost of the RAF staff is and average of R456 000 per employee. This would amount to a total expenditure of R12.49 billion in administrative costs, if the NHI fund was run at the efficiency levels of the RAF, with the projected NHI Budget. It is important to note, that RAF staff only managed to pay 41% of liabilities in any given year.

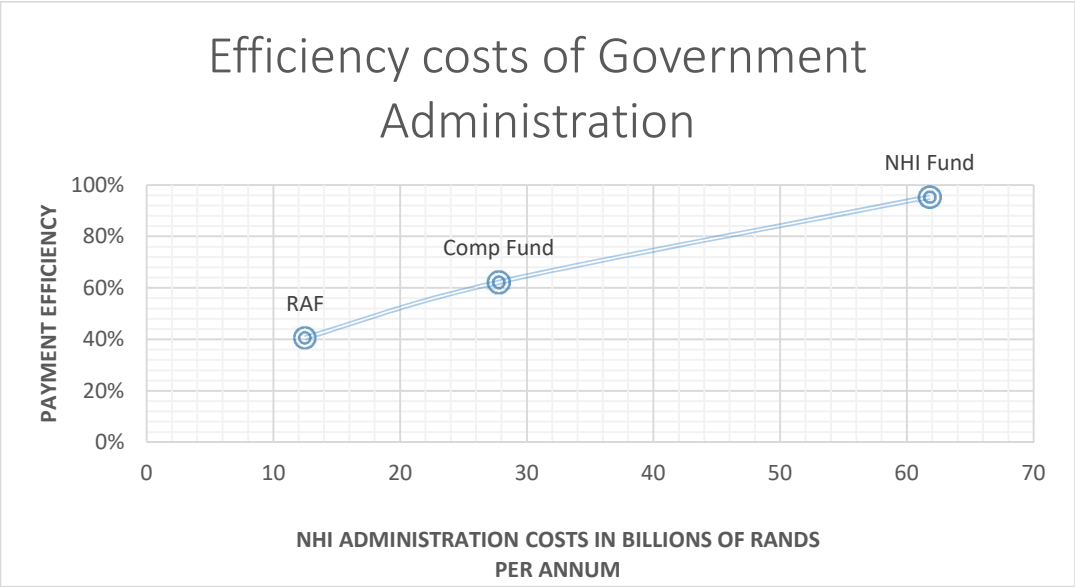
14. The costs of administering the NHI Fund privately at a premium of 4.5% (the premium paid by GEMS[10] to its administrators for administration without managed care being included) would amount to R 11.52 billion per annum. If the private healthcare industry average of 10.98% for administration costs[11] is used to determine potential administration costs of the NHI Fund, this will amount to R28 Billion (Of the projected R256 billion NHI budget). Although the costs of staffing the NHI Fund at the efficiency of the RAF will cost R12.49 billion per annum, the biggest concern is that only 41% of claims would be paid in any given year. At a cost R27.78 billion, the NHI Fund could run as efficiently as the Compensation Fund, with 61% of claims being paid in any given year. To reach the efficiency levels of private scheme administrators, where 96.4% of claims get paid annually, the government run administrative costs could escalate to R61.78 billion (See Figure 1), when exponential equations are used. This would mean that the government administration of the NHI Fund at levels that equal the efficiency of private medical administrators could cost 24.1% per year and require 226 300 staff members, as opposed to the 4.5% - 10.98% costs of private medical scheme administration.

14.1 In the absence of documented research used by Government to decide on a single payer/purchaser NHI model in the NHI White Paper, one has to assume that one of the

[8] Compensation Fund Annual Report 2014/15
[9] Road Accident Fund Annual Report 2014/15
[10] GEMS Annual Statutory Return (Section 37) Report 2013
[11] Council of Medical Schemes Annual Report 2014/2015

government considerations was the 1 - 2% administration costs of the Taiwanese NHI[12] in making this decision. Considering the South African situation, it is clear that even the most efficient private medical scheme administrators cannot run the administration of the NHI at such low administration figures and government administration is even less efficient. This administrative cost burden appears to have gone unconsidered in the costing models of the NHI and in the decision of utilising a single payer model.

Figure 1 Efficiency costs of Government Administration of NHI Fund



15. A further unconsidered cost in the NHI White Paper is the potential escalation in the costs of running the Office of Health Standards Compliance once the NHI is implemented. In Paragraph 23 of the NHI White Paper, it is indicated that Health Facilities that are eligible would have been certified by the OHSC by the final phase of implementation of the NHI (2025). According to 2015 claims data from a major medical scheme administrator, there are currently a conservatively estimated 600 clinics in the private sector and at least an additional 32 600 private healthcare practice facilities[13] that would need to be inspected by 2025 to be included for accreditation in the NHI. Figures provided by Medpages[14] indicate that there are 12390 Hospitals and clinics registered on their database, with an additional 62 168 registered private practices.

16. In 2014/2015, the OHSC inspected 417 government facilities. The number of employees at the OHSC was 96 in 2015/16 and will be increased to 137 in 2017/18[15]. There is no indication in

[12] Song, Y-J. 2009. "The South Korean Healthcare system". *Japan Medical Association Journal 52(3)*
[13] Major Medical Scheme Administrator 2015 Claims Figures
[14] Medpages figures. www.medpages.co.za/stats
[15] Office of Health Standards Compliance. Annual performance plan 2015/16 to 2019/20.

the OHSC Annual Performance Plan document, which extends to 2020, of the creation of inspectorate capacity to inspect the approximately 33 200[3] to 74 558 private facilities for inclusion in the NHI. No inspection of private facilities has commenced to date in 2016 and norms and standards for these inspections have not been promulgated by the Minister of Health. Once these norms and standards get promulgated, it would entail that the OHSC would have to inspect between 8300 and 18640 private facilities annually in the 8 years between 2017 and 2025 for possible inclusion and accreditation in the NHI. This is due to a certification from the OHSC only being valid for 4 years.

17. With their current staffing complement of 7 inspection teams of 5 inspectors each, this would entail that each team will have to inspect between 5.2 and 11.07 facilities in every work day (of which there are 229 per employee annually). In 2014/15, each team was on average, able to inspect one facility every 4-5 work days. In order to do the necessary inspections, there would have to be between 182 and 388 teams of 5 inspectors employed by the OHSC, giving it a staff complement of between 910 and 1 938 inspectors. There is currently no indication in the budget of the OHSC, which is projected up to 2020 in their annual performance review, of the necessary budget availability to increase their inspectorate capacity to these levels. The current inspectorate budged is R28 million per annum, which would need to be expanded to between R227 million and R484 million (average CTC of R250 000 per inspector), which only includes salary costs and does not address the potential escalation in travel and accommodation costs for this inspectorate force.

18. There is currently no indication in either the projected NHI costs or the OHSC strategic budget to 2020 of accommodation for these additional funding requirement for the inspectorate to operate as required in the White Paper.

19. A further administrative issue regarding the NHI roll-out, is the issuing of an NHI card that is envisioned in the second phase of implementation (Paragraph 17 of NHI White Paper). The addition of an NHI card adds a potential further bureaucratic component to the system. Between July 2013 and January 2015, the Government managed to issue approximately one million smart Identity cards[16]. At a similar rate of issuing 1 Million cards in 18 months, it could conceivably take the Department of Health (DOH) 82.5 years to issue 55 million NHI cards. Various alternative administrative points of issue would have to be considered for this initiative to work. The current cost of the South African Identity card is R140, for a re-issue. If the NHI card costs were similar, the cost of DOH issuing NHI cards for the entire population of

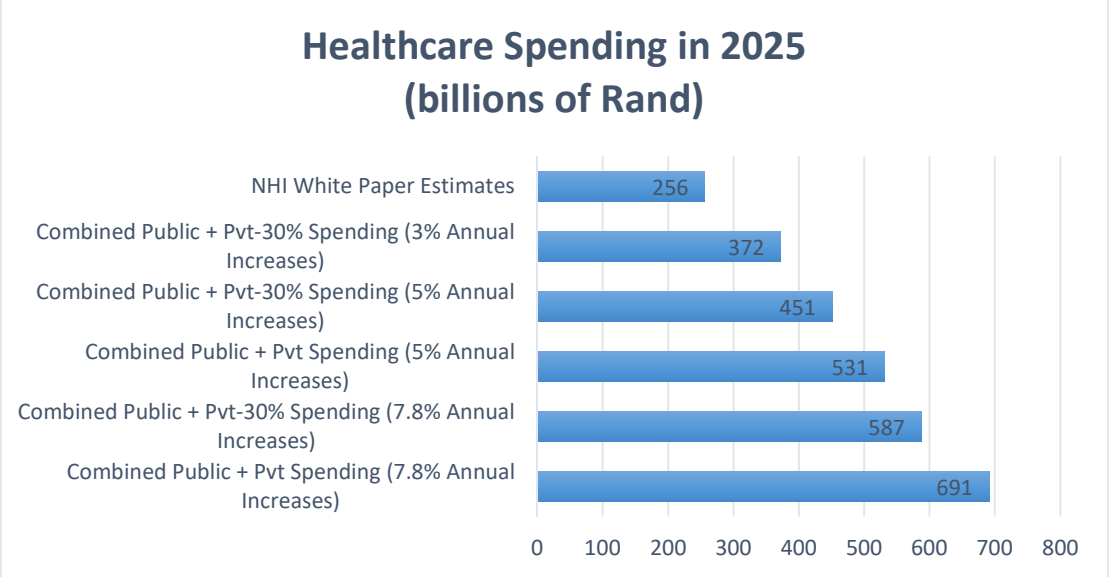
[16] Department of Home Affairs. 2015. Smart Identity Document (ID) card roll-out. http://www.gov.za/about-government/government-programmes/smart-identity-document-id-card-roll-out

55 million South Africans, could be as much as R R7.7 billion. At a cost of R10 per card, the costs would amount to R550 million. It is not clear if and how these costs are included in the financial modelling in the White Paper. The motivation for an NHI card is clearly taken from the Taiwanese model[17] where an NHI card is used to electronically store patient medical information. There is no indication in the NHI White Paper whether the South African card would function in the same manner, or whether it is simply an identification tool. If it is an identification tool, it could be replaced by an SA ID document without additional costs. If health information is going to be carried on the card in electronic fashion, consideration should be taken of the costs and bureaucracy involved with issuing of these cards.

20. Figure 2 illustrates the projected NHI spend, if one looks at different inflation figures. It can be seen that combined Public and Private spending at 3% annual inflation and a 30% discount on Private spending (attributable to a government control of private costs) will lead to estimated spending of R372 billion on Healthcare in 2025. A 3% annual inflation is, unfortunately an unlikely scenario. A 5% annual inflator in the scenario described previously will lead to R451 billion in Healthcare spend by 2025. In the worst case scenario, current private and public spending is combined with a 7.8% annual inflator, without any cost control discounts in the private sector, which will lead to spending of R691 billion in 2025. In our opinion, the most realistic cost estimate is combined Public and Private spend (minus 30% government cost control), with a 7.8% annual inflator. This estimates a cost of R587 billion for healthcare spend in 2025. None of these figures take into account the decline of the Rand exchange rate to the dollar and the effect this would have on costs. The rand has depreciated by 25-30% against the Dollar between 2010 and 2016. All of these figures will make for an unaffordable government funded NHI system.

[17] Song, Y-J. 2009. "The South Korean Healthcare system". *Japan Medical Association Journal 52(3)*

Figure 2: Healthcare Spending Estimates with different scenarios



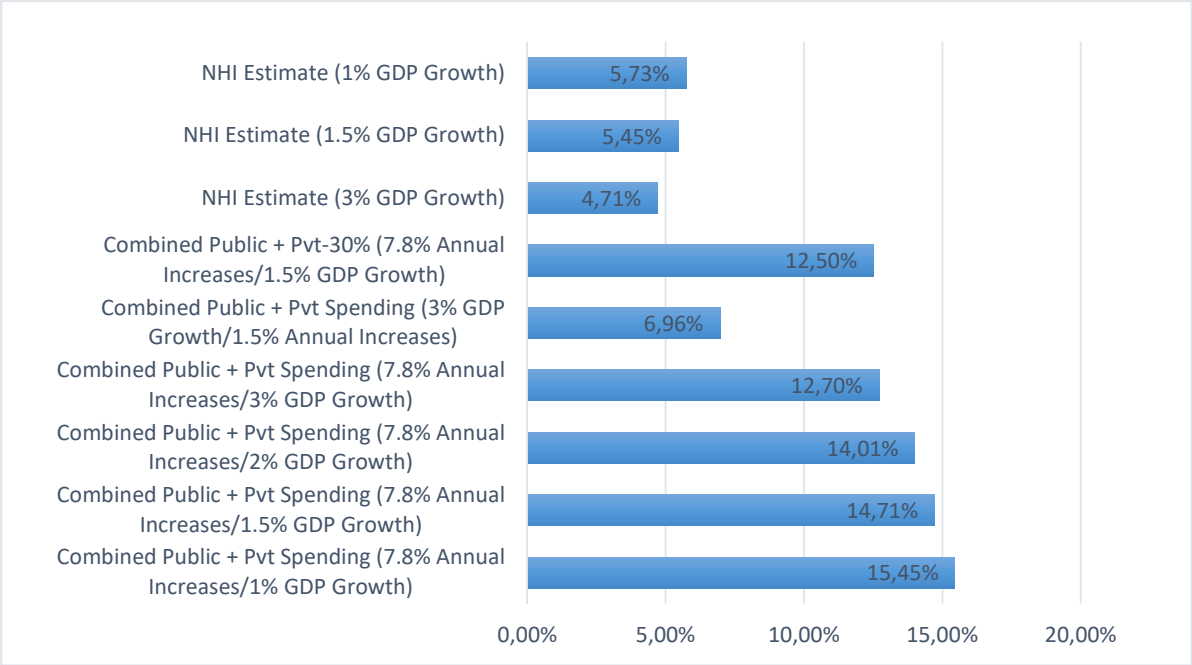
21. In response to Paragraph 257 of the White Paper, Figure 3 estimates the level of Healthcare spend as a percentage of GDP in different growth scenarios. It can be seen that the current NHI estimate at 3% GDP growth would result in healthcare spend equalling 4.71% of GDP. If GDP growth declines to 1% annually (2016 growth set at 0.1% by IMF[18]) NHI spending would total 5.73% of GDP at the current R256 billion estimate. If one looks at the previous projection of Public + Private spending (30% cost control discount applied) at 7.8% annual inflation, the amount of R 587 billion will equate to 12.50% of GDP at a GDP growth rate of 1.5% annually. Taking into account that South African Government budgeting is currently not allowed to exceed 25% of GDP, it can be seen that this healthcare spend would lead to half of the Government budget being spent on Healthcare. This would create a situation that is neither affordable, nor feasible. Most of the other spending scenarios generate more costly situations than this.

21.1 The affordability of the NHI is definitely a core policy issue. One cannot ignore considering the costs involved, nor can we accept the statement by the DOH in the White Paper that cost consideration is "the wrong approach". In SAPPF's opinion, South Africa cannot afford the NHI system in its current format. This does not, however, mean that South African cannot afford UHC. What is does imply, is that a different, more appropriate funding model needs to be considered. The low levels of employment and the small base of tax payers in South Africa compared to other countries using tax-funded public health systems is an indication that one needs to have higher levels of employment to sustain such a system. Affordability is a core

[18] IMF. World Economic Outlook- Uncertainty in the Aftermath of the U.K. Referendum, July 2016

issue. One cannot ignore this. Continuing to avoid investigating the costs involved will eventually bring us to a point where the affordability issue can no longer be ignored, by which time billions of Rands would have gone to waste on pilot projects and other administrative expenses in trying to implement this unaffordable system.

Figure 3: Health Spending as % of GDP in different scenarios



5. International Context

22. In SAPPF's point of view, there should be a distinction between *implementing the NHI* and *implementing Universal Health Care* (Paragraph 44). **Achieving Universal Healthcare is not dependent on the NHI single payer model being implemented.** The NHI is only a funding model. UHC will ensure access for all in an integrated system, without the costs of the NHI's proposed radical reorganisation of the health system, which will have to funded by the government.

23. Affordability of healthcare reform for South Africa is indicated by comparison to various other developing, middle income countries in the White Paper. In Paragraph 47 of the White Paper it is stated that "*Previous attempts of health care reform worldwide that did not encompass reforms to health care financing have not always been successful in some countries whilst countries such as Mexico and Thailand are examples of countries where attempts to transform health financing have been positive.*"

23.1 Comparing South Africa with these developing, middle income countries is an inappropriate comparison, as is illustrated in Table 4. This table illustrates the radical differences in

unemployment rates between South Africa and the countries used for demonstrative purposes. There are also large differences between the GINI coefficients of South Africa and these countries. On average, South Africa's unemployment figures are 6.7 times as high (25.4% vs 3.8%) as the countries it is compared to and the GINI coefficient is 47.8% higher than these comparative countries.

Table 4: Country Comparison of Unemployment and GINI Coefficient

(2014)	Population	Taxpayers	Taxbase	Unemployment	GINI
Mexico	122.3 Mil	46.3 Mil	37.8%	4.75%	48.1
Thailand	68 Mil	20 Mil	29.4%	0.9%	39.3
Brazil	202 Mil	50.5 Mil	25%	6.8%	52.9
Korea (2011)	49 Mil	13.5 Mil	27.5%	2.7%	31.3
Average	**110.3 Mil**	**32.6 Mil**	**29.9%**	**3.8%**	**42.9**
RSA	55 Mil	5.7 Mil	10.3%	25.4%	63.4

24. Table 5 compares levels of employment in South Africa to other countries with UHC systems. In Paragraph 49 of the White Paper, Brazil, Canada, Finland, Norway, Sweden, Thailand, Turkey and the UK are specifically mentioned as countries that successfully implemented Universal Healthcare. The average percentage of employed people in these countries, is 59.38%. It can be seen in this comparison that South Africa has 52% fewer employed people in the population than these countries mentioned in paragraph 49 of the White Paper. When one includes other countries utilising UHC, such as Denmark, Mexico, France, Iceland, Japan, New Zealand, Costa Rica, South Korea and Australia, a similar employment pattern can be noted. This creates a major barrier for funding of the NHI through tax revenue, as there are simply not enough people that can pay for the system.

Table 5: Employment percentages[19] in selected Countries with Universal Healthcare

Country	**2014 (%)**
Brazil	65
Canada	61
Finland	54
Norway	62
Sweden	58
Thailand	72
Turkey	45
United Kingdom	58
Average	***59.38***
Denmark	58
Mexico	59
France	50
Iceland	70
Japan	56
New Zealand	63
Costa Rica	58
South Korea	75
Australia	61
Average (ALL)	***60.28***
South Africa	**39**

25. Table 6 illustrates the current South African tax base[20]. The narrow nature of the tax structure in South Africa is a large concern when it comes to the public funding of Government projects such as the NHI. The bottom brackets of tax liable individuals, earning less than R350 000 per annum, amount to 60.7% of all tax payers, yet only pay 10.5% of all personal income taxes. In comparison, the top 6% of tax payers, earning more than R750 000 per annum, pay 46.9% of personal taxes. This top 6% of tax payers, also only amount to only 0.6% of the entire South African population. In total, 12.8% of South Africans pay 100% of the personal taxes collected by South African Revenue Service (SARS). With such a narrow tax base, the proposed 4% increase in personal tax rates (Table 5 of the NHI White Paper), will be unlikely to increase the current R441 billion in personal taxes to the extent to cover any meaningful portion of the R184 billion shortfall illustrated in Table 2 of this SAPPF document at a 2% GDP growth scenario.

[19] World Bank employment to population ratio. http://data.worldbank.org/indicator/SL.EMP.TOTL.SP.ZS
[20] 2016 National Treasury Budget Review

Table 6: South African Tax base[18]

Tax Bracket (R '000)	Number	Percentage of Taxpayers	Percentage of Population	Percentage of Taxes paid
70 - 150	258 3046	36.3%	4.7%	2.7%
150 - 250	1 733 463	24.4%	3.2%	7.8%
250 - 350	1 071 798	15.1%	1.9%	10.9%
350 - 500	800 990	11.3%	1.5%	14.6%
500 - 750	497 722	7%	0.9%	17%
750 - 1000	197 813	2.8%	0.3%	11.3%
1000 - 1500	136 782	1.9%	0.2%	12.1%
1500 <	94 578	1.3%	0.1%	23.5%
TOTAL	**7 116 192**	**100%**	**12.8%**	**100%**

26. According to these SARS figures (Table 6), 63.9% of South Africa's personal income taxes are paid by 926 895 high earning individuals, earning above R500 000 per annum. The indication that medical schemes will cease to exist under NHI and direct access to high quality private healthcare is not a certainty in the NHI system, could raise some serious concerns amongst this particular group of tax payers. Having their right to access high quality private healthcare impinged upon, could lead these individuals to consider greener pastures. As it currently stands, 25.7% of all South African emigrations between 2006 and 2016, happened in 2015. 2016 showed a figure of 9.7% of emigrations in the 10 year period happening in the three months included in the survey[21]. There is thus currently a definite upward trend in emigration, amongst groupings that can afford to do so. Emigration is a financial possibility for the top four tiers of taxpayers and a mere 50 000 emigrations from individuals in each of these top four tax brackets (200 000 in total) could cut SA's personal income tax revenue by 21.5%. This would create serious funding issues for the South African government in all categories of spending, including healthcare and social services, having a devastating effect on tax buoyancy in South Africa.

27. An increase in VAT to pay for the additional costs of funding the NHI will not necessarily be a socially just funding method, as VAT is generally regressive. Increasing VAT will lead to having to consider making additional food and basic living items VAT exempt, to minimise the impact on the poor. Something to consider is that making medicines VAT exempt will actually help to bring down the price of healthcare in South Africa.

28. It is important to note that the cost of increased taxation in the form of a payroll tax on employers will ultimately be passed on to consumers through higher prices. This will, in turn, result in a loss to consumer welfare through the erosion of disposable income. The additional

[21] StatsSA Community Survey 2016

burden imposed on employers will also increase the labour cost which will, in turn, limit job creation and place downward pressure on salaries. Such effects on the labour market may be detrimental to South Africa, given that we already struggle with high unemployment and where job creation is explicitly stated as one of government's main objectives. This increased taxation will also be added to any demands placed on the employer by the proposed minimum wages that are currently in the process of being implemented. One would hope that future employer taxes to fund healthcare will be considered in the current minimum wage negotiations, as it could have an additive effect on employment costs if it needs to be added at a later stage.

28.1 It is important to consider that any increase in taxes for the purposes of funding the NHI, should be ring-fenced in the fiscus, for this purpose. Paying increased taxes to fund the NHI will reduce to the expendable income of tax payers, thus reducing their ability to pay cash for any further medical treatments or medical scheme membership. If this increased spend is not ring-fenced for healthcare purposes in the government budget, tax payers can be seriously prejudiced in that additional money spent, supposedly on healthcare, does not go towards healthcare, which may then require additional personal expenditure on their side.

29. It is indicated that the implementation of NHI will take into account other country's experiences and global lessons learnt in the development of UHC (Paragraph 50).

29.1 There are several examples of lessons learnt internationally regarding universal health coverage that appear not to have been taken to heart in the South African context. If one looks at the case of South Korea specifically[22], a National Health Insurance was implemented over a twelve year period. The government mandated medical insurance for companies with more than 500 employees and this was subsequently extended to the whole nation in 1989. This system ran smoothly until 1997, when a major economic crisis hit South East Asia. There was an increasing annual deficit in the NHI after this period. The South Korean government continued to raise the contributions to try and make up the deficit, but did not succeed in doing so. Increased government funding was not solving the problem, as South Korea was unable to control health care expenditure. The South Korean Government assumed exclusive control over medical care financing without including medical professionals in the policymaking process. Organised medicine complained that only 65% of customary medical costs were reimbursed by the government insurance system. 90% of the South Korean system

[22] Lee, J-C. 2003. "Health Care Reform in South Korea: Success or Failure". American Journal of Public Health 93(1)

was based on Private Fee for service consultations, with only 10% of services performed by public facilities, which contributed to raising costs. In 2009, there were 49 238 227 Koreans registered with the NHI. Of these, 57.7% (28.4 million) are employee insured members, who each contribute 5.08% of their annual income towards NHI, with their employer contributing the same amount. Self-employed, insured individuals amount for another 38.6% (18.9 million) members, who contribute various amounts. The government is responsible to provide coverage for the poor and indigent, who constitute 3.7% of the population[23]. There is a co-payment system of 10% to 20% of inpatient costs and between 30% and 50% of outpatient consultation costs. This research indicates that the South Korean Government is struggling to fund healthcare for the 3.7% of the population that cannot afford to self-fund.

29.2 To compare with South Africa, South Korea has 47.4 million users of the NHI that self-fund at a rate of between 6% and 10% of their annual income along with co-payments ranging from 10% in-hospital to 50% of outpatient costs. Despite this massive funding base, the government is struggling to fund the 3.7% of the poor and indigent in the NHI. South Africa has 5.7 million taxpayers who will be funding 55 million South Africans, without any co-payments, at a government suggested rate of a 4% tax increase. Based on the Korean model it is concerning that the South African funding approach to the NHI is insufficient, making the NHI system unaffordable. Further lessons from the Korean system for the implementation of NHI in South Africa includes that utilising an NHI based system in periods of financial crisis does not work. South Africa is undoubtedly experiencing a financial crisis with twin deficits, low growth and a domestic currency which serves as a proxy for emerging market currencies and hence is subject to extreme volatility. Trying to implement an NHI in such circumstances is unlikely to succeed. A second lesson from the Taiwanese case study is that not including medical professionals in the policy making process, such as the NHI Fund and a Minister unilaterally determining reimbursement amounts for services, could create various implementation problems.

30. Similar to South Africa, the republic of Ireland published a Universal Healthcare Insurance (UHI) White Paper in 2011[24]. This White paper did not allude to any costing of the Universal Healthcare system and did not describe the basket of services offered under the Universal Healthcare Insurance. In 2015, it has come to light that Ireland cannot actually afford the system, following costings and analysis from the Economic and Social Research Institute

[23] Song, Y-J. 2009. "The South Korean Healthcare system". *Japan Medical Association Journal 52(3)*
[24] Irish Times. "An outstanding policy failure on universal health insurance". 23 November 2015

(ESRI). The ESRI study, which was based on the White Paper details, showed the [Irish] Government's proposed model "is not affordable now or ever"[25]. UHI proved a vote winner in the 2011 general election. However, the [ruling] party's failure to cost its own proposals then, and the Government's subsequent failure to do so until 2015 represented the "outstanding policy failure of the Coalition administration".

31. There are two prominent countries that utilise a single payer model, such as that proposed by the NHI. These are Canada and Taiwan.

31.1 Looking at the situation in Canada[26], it is seen that Canada has the second most expensive healthcare system as a share of the economy and adjusting for age. Long wait times in Canada have also been observed for basic diagnostic imaging technologies that many countries take for granted, which are crucial for determining the severity of a patient's condition. In 2013, the average wait time for an MRI was over two months, while Canadians needing a CT scan waited for almost a month. These wait times are not simply "minor inconveniences." Patients experience physical pain and suffering, mental anguish, and lost economic productivity while waiting for treatment. One recent estimate (2013) found that the value of time lost due to medical wait times in Canada amounted to approximately $1,200 per patient. There is also considerable evidence indicating that excessive wait times lead to poorer health outcomes and in some cases, death. Dr Brian Day, former head of the Canadian Medical Association recently noted that "*delayed care often transforms an acute and potentially reversible illness or injury into a chronic, irreversible condition that involves permanent disability*." New research also suggests that wait times for medically necessary procedures may be associated with increased mortality. One of the important statements of this report, was that it was important to recognize that a single-payer model is not a necessary condition for universal health care. There are ample examples from OECD countries where universal health care is guaranteed without imposing a single-payer model.

31.2 Research by the Fraser Institute published in 2015, on the cost of Healthcare insurance for Canada[27], it is illustrated that Canada consistently applies 23.9% of personal taxes that get paid towards Healthcare Insurance for individuals. The healthcare taxes of Canadians is quite progressive, with the lowest earners spending 3.5% of their income on health while the highest earners spend 13.2% of their income. They all receive equal health services. Between

[25] Irish Times. "An outstanding policy failure on universal health insurance". 23 November 2015
[26] Clemens J, Barrua B. "If Universal Health Care Is The Goal, Don't Copy Canada". Forbes Magazine, 13 June 2014
[27] Palacois, M; Barua, B and Ren, F. (2015) *Fraser Research Bulletin – The Price of Public Healthcare Insurance*

2005 and 2015, the costs of Canadian healthcare has increased 1.6 times faster than income, 1.3 times faster than the cost of housing and 2.7 times faster than the cost of food. Healthcare costs increased by 48% in the 10 year period, while the CPI increased by 17.3%. The CPI average increase for the period was 1.7%, while Healthcare inflation was 4.8% or a 2.8 multiple of the CPI Inflation. Although healthcare inflation under the single payer system in Canada is in line with a 2-3% above CPI expectation, the low base CPI makes this 2.8 times multiple quite high. Discovery Health illustrated at the health market inquiry that their premium inflation is currently 11.4%, where the SA CPI is 6.3%. Healthcare inflation in the South African Private Sector, which is branded as expensive in the NHI white paper, is only 1.8 times that of CPI. The proposal from the NHI White paper is thus to move from the current "expensive" two tier system to a single payer model, such as Canada, which could be considered even more expensive. This move is difficult to rationally justify.

31.3 The other single payer healthcare system is found in Taiwan[28]. Taiwan has 23 million people on their NHI. The Taiwanese government pays 23.2% and 76.8% of it is funded by individuals and employers. Every service delivered in the Taiwanese NHI has a co-payment of between R20 for GPs and R115 for hospitals and specialists. Taiwan spends 6.2% of its GDP on healthcare. Out of Pocket Expenses in Taiwan amounted to 35.8% of all healthcare spend in the country. The administrative costs of the Taiwanese NHI is only between 1% and 2% of the NHI budget, indicating a highly efficient administrative system. In comparison, as discussed earlier, SA Medical schemes run at costs of 10.9% and COID/RAF staff costs are between 5.3% and 5.8%, while these funds only managed to pay between 41% and 61% of annual claims. Waiting times in Taiwan are considered very low. This can be attributed to Taiwan having 17 doctors per 10 000 population in 2015, while South Africa had 6 per 10 000 in 2013[29]. The concerning flip-side of low waiting times is, however, poor quality of care, as Taiwanese GPs still see 50 patients in a morning shift. The other reason for the low waiting times is that Taiwan had 70.2 hospital beds per 10 000 population in 2014. South Africa, in comparison only had 28 beds per 10 000 population. The funding concern for the Taiwanese government is that healthcare costs often run over national budget and the government needs to pay extra to keep the system running. Despite this system, the satisfaction rate in Taiwan is 70-80%, which is actually less than SA's current public satisfaction levels of 81%[30].

[28] Song, Y-J. 2009. "The South Korean Healthcare system". *Japan Medical Association Journal 52(3)*
[29] Econex Report. August 2015. "Identifying determinants of and solutions to the shortage of doctors in South Africa: Is there a role for the private sector in Medical Education".
[30] StatsSA Annual General Household Survey, 2015

31.4 Having examined both the Canadian and Taiwanese single payer NHI models, it is not clear to understand the rationalisation of using these two countries as a motivation for South Africa to choose a single payer NHI model. Canada's healthcare inflation and costs are much higher than South Africa's, despite having a single payers system, while in Taiwan, 35.8% of Healthcare is provided for by out of Pocket payments. South Africa also does not have the administrative capacity to administer a single payer system at the same 1%-2% costs shown by Taiwan, as was illustrated earlier.

6. General Economic Concerns with the NHI Funding Model

32. The NHI White Paper postulates that a one year improvement in a nation's life expectancy can increase GDP per capita by 4% in the long run and higher productivity can lead to an additional 0.5% increase in GDP growth. Between 2004 and 2015, the average South African life expectancy increased by 9.1 years. The concomitant GDP growth, however, seems to be absent to support this theory in the South African context. This statement by the White paper is, in fact, disproved by the bulk of the academic literature, which strongly suggests that causation runs in the opposite direction. For example, this relationship was confirmed by a seminal 1996 study by economists Lani Pritchett and Lawrence Summers[31], who showed the dramatic effect that increases in incomes can have on health. They found a strong causative effect of income on infant mortality and demonstrated that, if the developing world's growth rate had been 1.5 percentage points higher in the 1980s, half a million infant deaths would have been averted. The most probable cause for the lack of correlation between life expectancy and wealth in South Africa is probably the 38% extended unemployment figures, which remains unconsidered. Even providing the indigent with all-encompassing free health services will not make up for lacking nutrition, sanitation and clean water that could be obtained by increasing employment levels.

33. By the government's own admission in the NHI White Paper, every R1 spent on healthcare creates 5 cents of extra economic activity in the long run. With no provision made for private spend in the NHI White paper, the economic effect of not spending R162 billion on private healthcare would reduce the SA GDP by R170 billion, a 4.2% reduction in GDP. Even if government spending on Healthcare is increased to 6%, as indicated in the White Paper, this would still lead to a 2% reduction in the GDP of South Africa. There is also the question of where the government funding will be obtained to achieve this additional R80 billion (2% of GDP) spend from the fiscus.

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[31] Pritchett, L. and Lawrence H. Summers (1996) *Wealthier is Healthier*. The Journal of Human Resources, Vol. 31, No. 4, pp 841-868. Restricted access available at: https://www.jstor.org/stable/146149?seq=1#page_scan_tab_contents

34. A further consideration that needs to be taken into account is that medical schemes and administrators are huge employers of skilled individuals and a large scale reduction in the number of medical schemes (as is foreseen in paragraph 402 of the White Paper) would lead to a reduction in the number of scheme administrators and ultimately, a massive reduction of employment in the healthcare industry. There is no guarantee that these skilled individuals would be absorbed in the public administration of the NHI fund.

34.1 Currently, there is also considerable debate about what would happen to the mandatory 25% reserves currently held by Medical schemes should schemes cease to exist. It is important to note that these reserves are the result of private contributions by private individuals and cannot arbitrarily be attached by government for incorporation into NHI funding, as this move is bound to be opposed at a Constitutional level by fund members being, in effect, deprived of their private property.

7. Summary

35. SAPPF is of the opinion that it is not feasable to fund Universal Healthcare by utilising tax revenue, as the South African Tax base is just too narrow.

36. South Africa does not have a large enough employed population in the working age groups to fund UHC exclusively through taxes.

37. Experience in countries such as Korea shows that UHC is difficult to fund, even with much larger tax bases and contribution percentages.

38. At 26.4%, South African unemployment levels are too high for a tax funded UHC system. Other UHC systems in middle income countries are based in economies with an average unemployment rate of 3.8%.

39. The potential administration costs of a large, government administered, single payer NHI Fund have not been considered in the NHI White Paper. The costs involved with government administered funds of a similar nature would indicate that private administration of the NHI fund would be the most cost effective option.

40. The costs of running the OHSC and issuing of 55 million NHI cards have also not been considered in the NHI costing projections.

41. The potential decline in GDP with the reduction of private healthcare spend and the reduction in healthcare administration employment with the reduction of private healthcare funders as proposed by the NHI White paper will have serious implications for the SA economy.

42. SAPPF would like to propose an alternative funding model, which would only cost the Government an additional R4.9 billion in annual expenditure.

8. SAPPF Comprehensive UHC Model – National Combined Health Insurance Plan (NCHIP) as alternative funding model to NHI

8.1 Background

43. Paragraph 50 of the NHI White Paper states that "South Africa's approach towards achieving UHC will be through the implementation of NHI". The World Health Organisation states that "*Universal health coverage (UHC) means that all people receive the health services they need without suffering financial hardship when paying for them. The full spectrum of essential, quality health services should be covered including health promotion, prevention and treatment, rehabilitation and palliative care.*" The position of the WHO continues, by saying that "*If people have to pay most of the cost out of their own pockets, the poor will be unable to obtain many of the services they need and even the rich will be exposed to financial hardship in the event of severe or long-term illness. Forms of financial risk protection that pool funds (through tax, other government revenues, and/or insurance contributions) to spread the financial risks of illness across the population, and allow for cross subsidy from rich to poor and from healthy to ill, increase access to both needed services and financial risk protection.*" There is a categorical statement in the WHO policy document that "***UHC does not mean free coverage for all possible health interventions, regardless of the cost, as no country can provide all services free of charge on a sustainable basis.***" The WHO continues to say that an important component of UHC is health financing, where attention needs to be paid to raising sufficient funds, minimising out of pocket payments through pre-payment and pooling and using available funds efficiently and equitably.

44. The WHO is thus quite clear that the UHC system needs to be affordable to the country. It does not specify free healthcare for all and does not specify a single payer system. SAPPF believes that the NHI model is not the correct one for the South African context, as it would prove unaffordable and would not achieve universal healthcare objectives. SAPPF would like to propose an alternative model to achieve UHC, which will incorporate some of the work already done in preparation for the NHI, but not the NHI funding model or the proposed radical (expensive) changes to the entire South African Healthcare system.

45. The SAPPF Proposal of a National Combined Health Insurance Plan (NCHIP) is based on the implementation of a number of policies that were previously tabled, but now discarded, along with a number of other changes to the funding environment, including changes to the Labour Relations Act, 1995; The Medical Schemes Act, 1998; the Compensation for Injuries and Diseases on Duty Act, 1993 (COID Act) and the Short Term Insurance Act, 1998. These changes

can happen concurrently, which will provide an environment conducive to enabling Universal Health Care in South Africa. The basis of the proposal is the expansion of the utilisation of Private Health Services, without the alienation of private providers and without creating an unaffordable system to the country. The proposal will be described by addressing the following :

a) Introduction of Mandatory Low Income Medical Scheme (LIMS) cover for all Employees
b) Introduction of Mandatory Gap Cover for all employees
c) Introduction of a revised NHI Fund
d) Introduction of Public Private Health Partnership and Private Sector Reforms
e) Current White Paper Proposals to be kept active
f) Funding of the NCHIP

8.2 Introduction of Mandatory Low Income Medical Scheme cover for all Employees

46. The first step to the NCHIP will be mandatory enrolment of all currently uninsured employees in low income medical schemes. In the latest available figures, there are 3.9 million main members of medical schemes[32]. The total number of employed persons in South Africa is 15.6 million, according to StatsSA[33]. If these 3.9 million current members and the estimated 2.39 million working dependents are subtracted from the workforce, this step would add an additional 9.3 million people to the Medical Scheme environment. Along with the remaining 2.5 million dependents[34], this will total 18.1 million South African citizens covered by health insurance. These LIMS members will also be able to access services through the NHI Fund, which is discussed in paragraph 51. The indication from medical schemes at the Health Market Inquiry is that this step should lead to a decrease of 20% in medical scheme premiums across the population, due to enlarged risk pool and cross subsidisation of the sick by young and healthy members. The process is, of course, not quite this simple and there would be various other factors involved in this process. The reconsideration and introduction of the *Risk Equalisation Fund* (REF) for medical schemes will also help to pool risk further, reducing the costs of underwriting. These step would require changes to the Medical Schemes Act, as the PMB basket in LIMS will look different from that in the current scheme environment. It will

[32] Council of Medical Schemes Annual Report 2014
[33] StatsSA. Quarterly Labour Survey, 1st Quarter 2016.
[34] Council of Medical schemes Annual Report 2014/15

also require changes to the Labour Relations Act, to enforce the mandatory enrolment and funding of this benefit by employers.

8.3 Introduction of Mandatory Gap Cover for all employees

47. The second step would be for all employers to provide all employees with a mandatory gap cover insurance product, which will cover any further unforeseen medical expenses and costs in hospitals that could potentially lead to financial hardships and co-payments, if medical expenses are at a higher level than that covered by current medical scheme rates. This will broaden the risk pool further and will create and additional funding mechanism, which will further increase access to affordable health services of South Africans. A general overview of currently available gap cover products in the market show these can be acquired for as little as R79 per month per employee. This will require changes to the Labour Relations Act and the Short Term Insurance Act.

8.4 The Revised NHI Fund

48. As previously indicated, the introduction of LIMS and REF should reduce premiums in the medical scheme market by 20%. In order to realise a progressive taxation system, in concert with the transformative elements in the Constitution that concurrently improves access to quality healthcare for all, this 20% saving in premiums will not be passed on to medical scheme contributors, but will be pooled using a Medical Scheme Levy in a revised NHI fund. This fund will be utilised for the express purpose of funding healthcare for poor and indigent members of society that are currently utilising public sector health services, by paying for services provided to these people by private doctors/ facilities. At the latest available medical scheme contribution figures (2014), a 20% contribution would lead to an annual income of R26.6 billion for the revised NHI Fund. This is also a progressive payment model, with the rich subsidising the poor, without an increase in taxation. The R26.6 billion budget would account for 49.5% of all Government spending on *District Health Services* in 2012/13 (R53.7 billion).

49. The revised NHI Fund will also be further expanded by contributions from employers that would have previously been paid to the Workmen's Compensation Fund. This would lead to an additional R 8 billion in annual contributions to the revised NHI Fund. The Workmen's Compensation Fund would cease to exist in its current administrative format and payments for Injury on Duty (IOD) claims will be administered by the revised NHI Fund. The administration of the revised NHI Fund will be put out to tender on a 5 yearly basis and all Medical Scheme Administrators would be invited to tender for administration of the fund. This would lead to the most efficient and cost-effective way of administering the revised NHI

Fund, as well as compensation for IOD claim. It can be clearly seen from the failures in administering the Compensation Fund that government administration of a fund of this kind will not lead to efficiency or cost effectiveness.

50. Medical treatment of victims of road accidents will also be funded by the revised NHI Fund. The cost of any claims where the Road Accident Fund is liable for medical expenses, will be pre-funded by the NHI Fund and the costs will be claimed back from the Road Accident Fund.

51. The revised NHI Fund will enhance access to private healthcare for the poor and indigent, as the R26.6 billion budget is equivalent to 49.5% of public sector spend on district health services in 2012/13. The primary focus will be on access to primary healthcare, by contracting private providers of primary healthcare services with the revised NHI Fund. This contracting will happen on a capitation fee basis and will greatly increase access to primary healthcare of all South Africans. Patients will thus be able to utilise private sector primary healthcare services in their area, and will be referred on to secondary and tertiary services in the public sector as required.

52. Savings with the utilisation of capitation payments will also allow for further contracting to happen with specialists to provide vital services such as gynaecological consultations as well as radiology services. Government in-patients could thus be transported to a radiology department at periods of low utilisation (night time), and MRI scans etc., for which there are currently long waiting periods, could be administered. Procedures for which there are currently long waiting periods in public health facilities, such as hip replacements surgeries and cataract surgeries, could also be contracted with private providers utilising Global fee arrangement. Current reserve funds from the Compensation Fund (Estimated R52 billion) that are being administered by the Public Investment Corporation, can also be transferred to the revised NHI Fund for utilisation as reserves.

53. In order to establish this revised NHI Fund, changes would have to be made to the Medical Schemes Act; the COID Act; the Road Accident Fund Act and the National Health Act. An NHI Fund Act would have to be drafted, which would include functions of the COID Act and would also contain elements of the Medical Schemes Act.

8.5 Introduction of Public-Private Health Partnership

54. The Public-Private Health Partnership will be the vessel which is utilised for private practitioners to contract with the revised NHI Fund to render services to the public, based on a capitation fee payment arrangement. This capitation fee arrangement must take into

account actual practice costs of the private practice. This will increase access to healthcare for all citizens, without imposing an additional cost burden on government while concurrently reducing the burden on public health facilities and staff. Certification for service delivery will still occur under the ambit of the OHSC. After the funding of capitation agreements with primary healthcare providers, surpluses in the revised NHI Fund will be utilised for contracting with medical- and surgical specialists, which will occur on a "needs" basis on a regional level, based on the required speciality needs and the waiting periods for specialist services in a specific area. This will lead to a managed care approach of purchasing private specialist and hospital services in a specific areas with specific providers and hospitals.

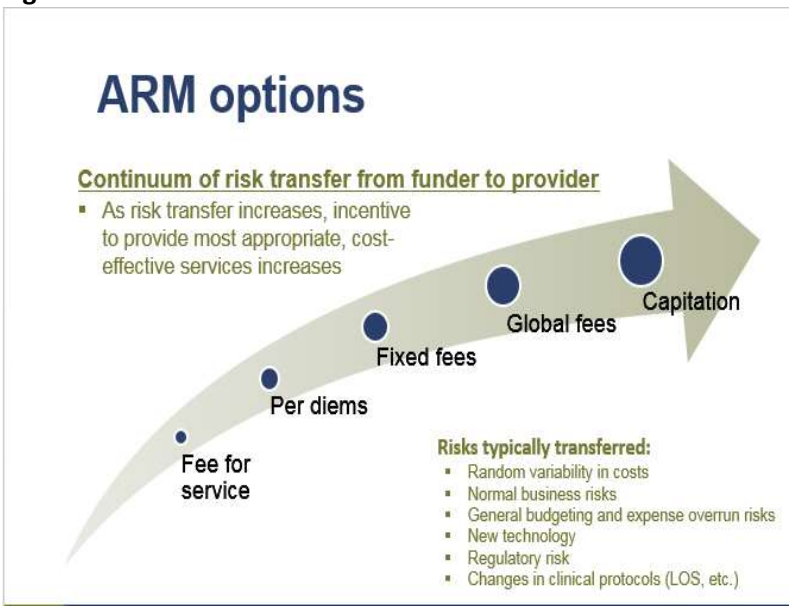
8.5.1 Reforming the private sector

55. SAPPF contends the private sector is an asset worth protecting. That is not to say that the sector is not in need of reform. This fact has been acknowledged previously by SAPPF and forms an important element in the SAPPF submission to the Health Market Inquiry (HMI), which is publically available.

56. Some examples of reforms that will make private healthcare more affordable and accessible include the following:

- Integrated practice units
- Emerging Technology
- Alternative Reimbursement Models

Figure 4 Alternative Reimbursement models



8.5.1.1 Integrated Practice Units

57. The WHO describe integrated practice units as a basic requirement for a UHC system. The systems envisaged by Michael Porter *et al*[35] will require amendments to both the NHA and the HPCSA Ethical Rules but hold clear opportunities for developing strategies that will create economies of scale and structural benefits that will allow closer integration between state and private healthcare services.

8.5.1.2 Emerging technologies

58. Another area that will undoubtedly bring down costs is the increasing use of emerging technologies to bring healthcare services within reach of rural communities.

8.6 Current White Paper Proposals to be kept active

59. There are various proposals in the White Paper that will help to improve the quality and provision of healthcare services to all South Africans. The OHSC is one of the current proposals that will definitely help improve quality of public health services. There will have to be a major increase in the number of inspectors, to deal with the burden of inspecting all public and private facilities every four years. Current inspection rates indicate that the OHSC will have to employ between 910 and 1 938 inspectors to have the necessary inspection capacity. The introduction of Municipal Ward-Based Primary Health Care Outreach Teams to strengthen public primary health care is an important measure that is not reliant on the introduction of the NHI. A re-introduction of an integrated school based health system and establishment of district clinical health teams will also improve primary health service delivery in the public sector. Centralised procurement and the decentralised distribution of medication could still occur, as well as the continued improvement and upgrading of public health facilities as was currently envisioned.

60. The current Competition Commission Health Market Inquiry is also necessary to be completed, so that competition in the private space can be normalised and that legislative measures that have been lacking, such as annual PMB review can be implemented.

8.7 Funding of the NCHIP

61. The revised NHI Fund will be funded by the funds that are saved by 20% decrease in underwriting costs caused by mandatory enrolment in medical schemes for all employees, as well as the mandatory contribution of all employers that were previously administered by the

[35]Porter, M.E and Kaplan, R.S. 2015. "How should we pay for Healthcare?". Harvard Business School Working Paper

Compensation Fund. This would create a budget of R34.6 billion annually, in 2016 currency. The fund would also have R52 billion in reserves, obtained from the reallocation of current reserves from the Compensation Fund. The Government expenditure on all district health services in the 2012/2013 Financial year, amounted to R53.7 billion for all provinces. 64% of district health services could thus be funded out of the revised NHI Fund with this funding basis, 49.5% if Compensation Fund income is ring-fenced and excluded from PHC payments. This cost would not add any additional costs to the government budget and would essentially be funded by the private employers and private individuals, without adding to their individual expenditure. It would also not add any additional financial burden to individual contributors to medical schemes, as the savings due to risk pooling via mandatory enrolment will create this surplus.

62. Mandatory enrolment of all employees on medical schemes will be funded by employers and tax credits can be created for this. Research published in 2006 by Sharon Swanepoel[36] indicated that the costs for LIMS would be R200 for the main member per month. With an annual inflator of 6.7%, this would amount to R382 per member per month in 2016. The total costs to employers, to add the additional 9.3 million employees to LIMS would be R 42.6 billion per annum. A tax credit to reduce some of this burden on employers is an important part of this process, as the estimated 9.3 million employees that will now be cared for by private healthcare providers, will not be burdening the public healthcare system. If employees contribute R100 per month towards their own LIMS, the total cost to employers would be R31.5 billion per annum. This cost can be transferred to Government in the form of a tax credit. A further benefit to Government is that the cost to provide these individuals with access to healthcare is now capped at R31.5 billion, where it was previously an "uncapped" expense in public sector utilisation.

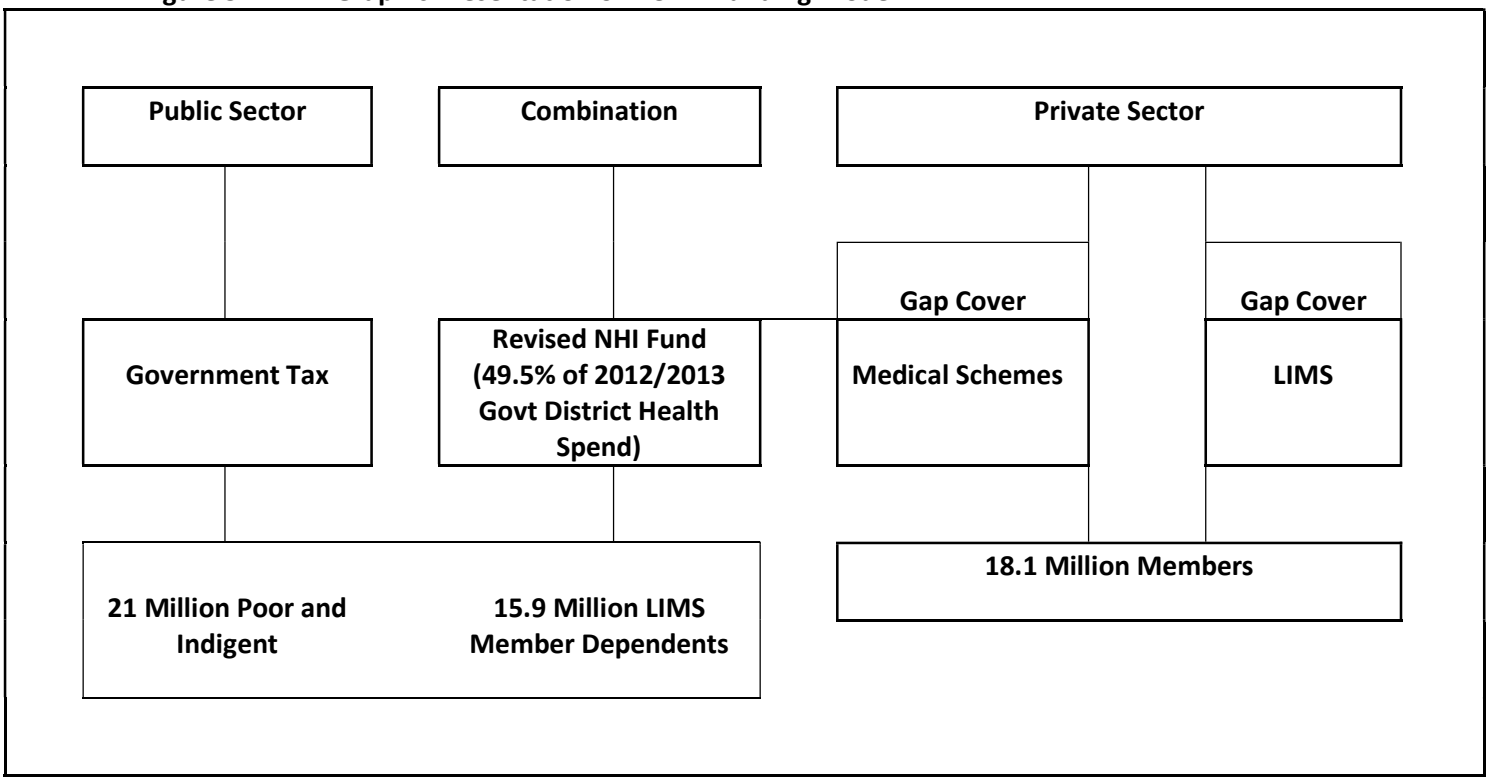
63. The outlays of providing gap cover for 15.6 million employees at a cost of R79 per employee per month, would be a total of R14.7 billion per year. This would negate any co-payments in Hospitals and would also reduce out of hospital co-payments. If employees fund 50% of the contribution, the cost to employers would be R7.4 billion per annum.

64. The public Health budget can also be reduced by R26.6 billion, due to the private sector now shouldering a larger portion of the patient care burden. Using these figures, one can introduce Universal Health Care at a maximum cost of R31.5 billion to Government, assuming a 100%

[36] Swanepoel, S. Healthcare for Low earners a step closer. http://ftp.bhfglobal.com/healthcare-for-low-earners-a-step-closer

tax credit for money spent on LIMS contributions and a R100 per month contribution by all employees. This will be offset by the smaller budgetary requirements of the Public Health System, as the revised NHI Fund, which is funded by a Medical Scheme Levy will contribute a further R26.6 billion in district health services. This R26.6 billion is equivalent of 49.5% of current Government spending on district health services in all 9 Provinces combined. The revised NHI Fund will not cost government anything and will further reduce the patient burden on the public sector by 50%. The public burden would amount to providing healthcare to 32 million South Africans, with a further potential 16 million of these patients being serviced in the private sector with the utilisation of the Private Health Access Fund. **The nett additional Government costs of the National Combined Health Insurance Plan, would thus be R4.9 billion, assuming a 100% tax credit on employers' LIMS contributions (and the corresponding R26.6 billion reduction in district health spending). Employers will spend an additional R7.4 billion annually on gap cover, while employees will contribute R18.5 billion annually in LIMS (R100 per month) and Gap Cover (R39.50 per month) contributions.**

Figure 5 Graphic Presentation of NCHIP Funding Model



8.8 Conclusion

65. SAPPF believes that this model addresses the Universal Health Care requirements of all South Africans, without placing an undue tax burden on the already small tax base and without any costly reorganisation of the entire healthcare system and healthcare funding environments.

It also improves equity and provides access to the private sector for people that currently utilise the public healthcare system, through the revised NHI Fund.