South African Institute of Race Relations NPC (IRR)
Submission to
The Davis Tax Committee
regarding the
funding of the proposed National Health Insurance (NHI) system
Johannesburg, 14th October 2016

Contents

Introduction

The Davis Tax Committee (the committee) has invited interested people and stakeholders to submit written comments, by 14th October 2016, on funding for the proposed National Health Insurance (NHI) system, as set out in the White Paper on the NHI (Version 40), which was published on 10th December 2015 (the White Paper).

This submission on the funding of the proposed NHI system 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 benefits the NHI system will supposedly bring. In practice, however, NHI will reduce, rather than expand, access to health care. It will also be extremely costly; and is likely to impose a crippling financial burden on an already struggling economy.

The proposed NHI system is also premised on a number of flawed assumptions, while it disregards various key issues that need to be taken into proper account, not overlooked. These include:

- the poor performance of the public health care sector;
- how the government's own regulations push up the costs of private health care;
- the unconstitutionality of the NHI proposals; and
- the practical measures that could be implemented to achieve universal health coverage in South Africa, without going the NHI route.

All these considerations need to be taken into account in deciding on the best way forward for the country, as emphasised by the IRR in its May 2016 submission on the White Paper to the Department of Health. For ease of reference, a synopsis of that submission is attached to this document, while the full submission is available on the IRR website and can readily be provided to the committee, should it so wish.

For the committee's purposes, however, the key question is the narrower one of how the proposed NHI system can be funded. This does not mean, however, that the weaknesses in the NHI – or the practical alternatives to this proposal – should be overlooked by the committee in assessing the affordability of the NHI.

The funding of the proposed NHI system

It is impossible to assess how the proposed NHI system could be funded without accurate forecasting on how much the system is likely to cost, both when it takes full effect and for at least ten years thereafter.

How much it will cost depends on various other factors, many of which are overlooked or inadequately clarified in the White Paper. These include:

- the benefits to be provided by the NHI;
- the costs of the bureaucracy required to administer the NHI;
- the impact of price controls and centralised procurement;
- the likely extent of fraud, corruption, and inefficiency;
- the number of health facilities and practitioners qualifying for participation;
- the pooling principle and its economic ramifications;
- likely rates of medical inflation in the future; and
- other important economic variables, from the value of the rand to interest rates, the growing burden of public debt, and the likelihood of South Africa having its sovereign credit ratings downgraded.

The benefits to be provided by the NHI

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 needs, and mental health services, along with 'prescription medicines', 'chronic disease management', and 'diagnostic radiology and pathology services'. Also 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). In addition, '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]

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 confined to funding. [*Saturday Star* 19 December 2015]

In 2009, when the ruling African National Congress (ANC) released a 200-page discussion paper on the NHI, Dr Jonathan Broomberg, chief executive of Discovery Health, 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'. [*The Star* 3 June 2009] This cost estimate from six years ago no doubt merits substantial upward revision if these are indeed the benefits to be provided by the NHI.

NHI benefits might instead be limited to the prescribed minimum benefits (PMBs) which the government requires medical schemes to provide to all their members. 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 would be R396bn. [*Business Day* 29 July 2015, *Mail & Guardian* 22 January 2015]

According to the minister of health, Dr Aaron Motsoaledi, what the NHI costs will 'depend entirely on how we design it'. This means that 'it could cost anything up to R1 trillion', depending on how it is planned. [*Saturday Star* 12 December 2015] As the minister indicates, the more benefits are included in the NHI, the more the new system will cost. This underscores the fundamental point that the costs of the NHI cannot be computed without knowing what its benefits will be. Without clarity on this point, the committee cannot realistically assess what the funding needs of the NHI are likely to be, or how these needs might be met.

The White Paper dismisses the need for accurate forecasting of the likely 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] But the question of what the NHI will cost must first be answered before funding options can realistically be considered.

The costs of the bureaucracy required

The costs of the major bureaucracy that will be needed to implement the NHI must also be taken into account. This issue is not covered in the White Paper and likely costs are thus difficult to quantify. What is clear, however, is that each of the new administrative entities envisaged will need to be suitably staffed, remunerated and equipped, and provided with appropriate office or other working space.

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.

Under the NHI system, 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 thus 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 'preventative, 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] Again, the specialists in these teams will have to be paid and equipped so that they can fulfil their functions.

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 be revised from time to time. Again, various costs will be involved in establishing these committees and in empowering them to fulfil their mandate.

Each district 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, and no doubt costly, task.

Above the primary level, there will be hospitals of six different kinds, from district hospitals (providing general medical services) to central hospitals (providing highly- and super-specialised services). Each hospital will need its own *hospital board*, so funds will again be needed for the remuneration and/or expenses of board members. Additional moneys will be required to train board members, improve their skills, and make it possible in time to delegate more managerial autonomy to them. [Paras 193-198, 208, 211, 212, White Paper]

Hospitals (like all other health facilities and health practitioners) will have to comply with the norms and standards set by the *Office of Health Standards Compliance (OHSC)* if they are to be accredited to participate in the NHI. The OHSC is already in existence but will have to be expanded if it is to cope with its increased responsibilities under the NHI.

All health care practitioners and facilities must be assessed and accredited by the OHSC before they may participate in the NHI. OHSC assessments must cover 'seven domains and six national core standards'. The seven domains range from patient safety and clinical care to facilities, infrastructure, corporate governance, and operational management (which in turn includes financial, asset, and human resource management). 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 actual task of accrediting and contracting with that health care provider will be carried out by another administrative entity, as explained in due course.

The OHSC already has an *inspectorate* to help enforce compliance with these norms and standards, but this may need to be expanded. It also has an *ombud* to investigate complaints by patients, but again this will have to be extended to cope with the volume of work likely to arise when 55 million South Africans are expecting to obtain 'quality' health care under the NHI. [Paras 215-218, 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 already been introduced. The existing system 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]

However, this is a miniscule portion of the demand that is likely to arise when all HIV-positive South Africans, currently numbering some 8.4 million [*The Times* 20 July 2016] become entitled to ARV treatment, from the time of their initial diagnosis, under the NHI system and South Africa's revised treatment protocols. The existing CCMDD programme will thus have to be greatly expanded to cope with the increased demand the NHI will generate.

A *National Health Commission (NHC)* is also envisaged 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 in the White Paper. But accreditation, to name but one example, 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 already certified by the OHSC 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'. [Paras 332, 333 White Paper]

This information to be submitted 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, which means the costs of doing so are likely to be high.

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]

However, 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 officials will be needed to marshal and maintain 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 the White Paper points out, a system of *'health technology assessment'* will also have to be established. Officials engaged in this function will have to decide on the 'introduction of interventions for health promotion, disease prevention, diagnosis, treatment, and rehabilitation'. According to the White Paper, 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 have been strongly criticised for not covering are thus 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]

The White Paper also stresses the need for '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'. Many more officials will be needed to make relevant decisions in this sphere. In addition, 'the list will [need to] 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] More officials will thus be needed to carry out these regular reviews.

Yet another new structure will also be required, in the form of the *NHI Commission*. This body 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 NHI Fund will routinely be assessed. [Para 329 (as included on page 62), White Paper]

Likely size of the proposed Provider Payment Unit alone

As earlier indicated, the NHI Fund will have eight units, including the Provider Payment Unit. This will presumably be responsible for making the payments due to hospitals, doctors, nurses, and other health care professionals for the health services they have rendered to patients. In assessing the likely size (and costs) of the Provider Payment Unit, some guidance may be obtained from the experience of the current Compensation Fund.

The Compensation Fund currently receives the mandatory 'workmen's compensation fees', which most employers and their employees 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 amounting to between R1.4bn and R2bn a year. The implications for the Provider Payment Unit of the NHI Fund are profound. Notes Dr Johann Serfontein of 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 by the White Paper 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 will require [the Provider Payment Unit of] the NHI Fund to employ between 52 000 and 160 000 people.' [*Business Day* 24 May 2016]

The Provider Payment Unit may also be made responsible for paying for all the medicines, medical equipment, diagnostic tests, and other goods and services that will be required in meeting the health care needs of 55 million South Africans. If so, a further 52 000 to 160 000 officials may be needed to handle this aspect of the payment process. Providing salaries, pensions and other benefits to all these new employees will not come cheap. Further costs will also be incurred in providing them with office accommodation, telephone and other services, and the like.

The Provider Payment Unit is also only a small part of the overall bureaucracy that will be needed to administer the NHI system. The costs of this bureaucracy should not be overlooked, as the White Paper does, but must be taken fully into account by the committee in assessing the likely costs of the NHI and how these could be funded.

The impact of price controls and centralised procurement

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]

According to the White Paper, the National Health Laboratory Service (NHLS) is also 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.

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 officials ever more work to do.

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.

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]

The White Paper simplistically assumes that price controls in all these various spheres will bring down costs and promote efficiency. However, since the government will dictate prices in all the spheres outlined above, market mechanisms will no longer be available for this purpose. This 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.

How the inevitable impact on costs is to be quantified, however, is a major challenge. Yet, unless the committee is able to achieve this, it will be even more impractical for it to put numbers on the revenue needed to fund the NHI.

Fraud, corruption, and inefficiency

As earlier noted, the NHI Fund will include, among its eight sub-units, a Risk and Fraud Prevention Unit. This will help prevent the large amounts of money to be collected within the NHI Fund (R256bn in 2025, according to the White Paper) from being eroded through fraud and corruption.

The White Paper 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 rather more briefly acknowledges the risk of 'regulatory capture, where those who write regulations bias them towards specific actors'. It also notes that officials may not always be blameless, for 'suppliers may bribe officials to overcharge for 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 suffice to do the job. The more likely outcome, however, is that losses to fraud, corruption, and theft in this centralised system will be substantial.

Adding to this likelihood is the fact that much of the government's procurement is already irregular, unauthorised, or wasteful. Kenneth Brown, chief procurement officer at the National Treasury, has recently warned that 40% of the government's R600bn budget for goods and services is being compromised through 'inflated prices and fraud'. [*Business Day* 13 October 206] Once hundreds of billions of rands are added to the state's procurement budget under the NHI system, the scope for corruption and abuse will increase – while the measures outlined in the White Paper to guard against this risk are unlikely to be effective.

Already, moreover, much of the public health budget is being compromised by this kind of abuse. In June 2015, for instance, a study carried out by the School of Public Health at the University of the Witwatersrand reported that the public health care system was 'sick with corruption and haemorrhaging money in irregular spending'. The study, carried out by Professor Laetitia Rispel and two of her colleagues, was based on reports by the auditor general over nine years, interviews with leaders in health care, 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 reported that 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 responded that 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' would be needed to counter existing abuses effectively. [*The Times* 26 June 2015]

Former finance minister Nhlanhla Nene (now an adviser to Thebe Investment Corporation) has also warned that fraud in the private health care sector is likewise rife. In July 2016, in addressing a conference of the Board of Healthcare Funders of Southern Africa (an organisation established to help serve the needs of medical schemes), Mr Nene said 'it was general knowledge that fraud is an "endemic" problem' in the medical scheme sector and that it costs the industry an estimated R19bn a year. [*Legalbrief* 19 July 2016] Yet current medical scheme administration is far more proficient than that which is likely to be provided by the NHI Fund. If current administrators cannot stamp out the problem of fraud, it is likely to rocket once the NHI is introduced.

Even if fraud and corruption can be countered effectively, along with the abuses inherent in irregular, wasteful, and unauthorised spending, the problem of inefficiency is likely to remain. The example of the Compensation Fund is again relevant here. So too is the extent of late payment for diagnostic blood tests and essential supplies in the health care sector.

As earlier noted, the Compensation Fund is responsible for paying out the claims submitted by employees who are injured at work, along with the claims put in by the doctors, hospitals, and other health facilities that have treated them. However, the Compensation Fund is notoriously inefficient and has often failed to pay out on claims 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 then 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. [*Business Day* 19 May 2015, 21 April 2016; *Legalbrief* 21 April 2016]

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]

Further evidence of the persistent inefficiency within the Compensation Fund has come to light in recent months. In August 2016 it emerged that 106 000 claims – all of which had already been approved by the fund's Medical Bureau for Occupational Diseases – had yet to be paid out. Roughly 45% of these claims were more than 15 years old, having been lodged before the year 2000. [*The Star* 16 August 2016]

The following month, commissioner Barry Kistnasamy, who had been appointed by Dr Motsoaledi in 2012, to replace Mr Mkhonto, told MPs that it would take 19 years to clear the backlog of unpaid claims accumulated by the fund. On his appointment, he said, he had found 'an under-resourced and dysfunctional organisation'. Added Mr Kistnasamy: 'Rooms were piled high with paper files, there was no system for tracking claims, and the auditor general had not given the fund a clean audit for more than a decade.' Since then, more staff had been recruited, a new IT system implemented, and external auditors appointed to get the fund's financial management in order. However, progress had been slow. The medical bureau had approved only 7 233 claims for the fiscal year ending 31 March 2016, of which only 1 755 had been paid out. Faster progress had since been made, with 4 754 claims approved in the first quarter of 2016/17 and 633 claims paid out. However, more than 100 000 claims still remained to be resolved. [*Business Day* 8 September 2016]

Financial management has also remained poor, the Fund admitting in September 2016 that it had spent R1bn 'irregularly' in 2015/16. However, the auditor general could not confirm the accuracy of this figure, as (in his words) 'the entity did not maintain proper records and adequate systems of internal control'. According to the Fund's annual financial statements, as tabled in Parliament, it also notched up R404 million (up from R17 million the previous year) in fruitless and wasteful expenditure. [*Business Day* 6 September 2016]

In addition to the unresolved claims lodged under the Compensation for Occupational Injuries and Diseases Act (Coida) of 1973, there also remain some 400 000 claims to be dealt with under the Occupational Diseases in Mines and Works Act (Odimwa) of 1973. Odimwa provides compensation to mineworkers who contract diseases while working on the mines, while Coida deals with claims for injuries and diseases contracted in other sectors.

Odimwa is funded by a levy on mining companies. However, the government has long failed to increase the amount of the levy, so as to generate sufficient monies to meet anticipated claims. In addition, writes DA shadow minister of health Wilmot James, the Compensation Fund has been allowed to become 'a total shambles'. Hundreds of thousands of ill

mineworkers and their families have thus been denied the help they should have received. In addition, once their claims have been processed, the compensation due to them could readily amount to some R24 billion, whereas the Compensation Fund has only R3.4 billion available. [Wilmot James, 'Motsoaledi must apologise to mine workers', Politicsweb, 7 September 2016]

The Compensation Fund points to the inefficiencies that are likely to arise when the NHI Fund takes on the task of paying, not only the claims for health services submitted by doctors, hospitals and other health practitioners and facilities, but also for all the medicines, medical devices, diagnostic tests, consumables, and other goods and services provided to patients. The Compensation Fund has failed to deal adequately with roughly 500 000 claims over more than 20 years. Imagine, then, the inefficiency and long delays that are likely to arise when the NHI Fund has to start paying out on many millions of claims each year.

The experience of the National Health Laboratory Service (NHLS) is also instructive here. 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. In addition, without accurate diagnostic tests, doctors are in the dark in treating many patients and cannot prescribe the drugs in fact required. Yet, despite its huge importance to the health system, by January 2015 the NHLS was in a critical condition. This was largely because provincial administrations had failed to pay it the billions of rand they owed. As the *Mail & Guardian* reported, 'the HHLS was then in debt to the tune of R5bn and was leaking skilled staff, while many of the employees who remained were demoralised'. [*Mail & Guardian* 9 January 2015]

Professor Francois Venter of the Wits Reproductive Health and HIV Institute commented that 'the NHLS was being held hostage by KwaZulu-Natal and Gauteng, which owe the lab millions'. Dr Motsoaledi denied this, blaming the NHLS itself for an allegedly 'chaotic, glitch-riddled billing system'. He also urged that the NHLS be paid directly by the National Treasury in future. However, questions remain as to how the massive debt already accrued will be paid. [*Mail & Guardian* 9 January 2015]

In the interim, staff losses are having a major impact on the functioning of a vital institution. 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]

The problem of late payment affects not only the NHLS but the whole of the public health care system. Poor supply chain management and a failure to pay suppliers have also contributed to shortages of medicines, medical equipment, consumables, 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]

The White Paper brushes over these issues, providing no guidance as to how they will be resolved under the proposed NHI system. But widespread inefficiency is again a fatal barrier to any attempt to quantify likely NHI costs with any degree of accuracy. Budgeted revenues are likely to be misdirected or to remain unspent. Huge contingent liabilities are likely to arise as unpaid bills accumulate. Litigation to recover unpaid bills is likely to accelerate, and these cases will have to be contested or settled, adding legal costs to the overall financial burden. Expensive claims against the NHI Fund for medical negligence are also likely to accelerate, if (for example) essential medicines and/or diagnostic tests cannot be timeously provided because suppliers have not been paid.

The number of qualifying health facilities and practitioners

As earlier noted, the OHSC is to be responsible for making the initial assessment as to whether a health care facility or practitioner qualifies for accreditation and hence for participation in the NHI system. (Thereafter, the accreditation process will be managed by another bureaucratic body, applying a complex set of criteria, as earlier outlined.) How many health facilities and practitioners are likely to qualify for accreditation by the OHSC is thus a vital question. Thus far, however, the evidence suggests that very few will do so.

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'. [John Kane-Berman, 'From *Last Grave at Dimbaza* to three tiny graves at Bloemhof', @Liberty, No 10, 24 June 2014, 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]

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. [Serfontein, FMF presentation, 20 April 2016]

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. On this basis, 55 million South Africans will have to be served by the 16% of public facilities that currently comply with OHSC norms and standards and so qualify to form part of the NHI system. [*Business Day* 24 May 2016; Serfontein, FMF presentation, 20 April 2016]

This, of course, could vastly reduce the NHI funding requirement. Some 84% of current public health facilities would presumably have to close down, as there would be no funding available for them outside the NHI system in which they would not be allowed to participate. The unmet demand for health services would be enormous – as would the public's sense of betrayal – but NHI costs could then be limited to 16% of the current health care budget or roughly R28bn.

In practice, of course, some other solution would have to be found: perhaps by waiving relevant norms and standards for many public health facilities. Again, however, what this issue underscores is that the committee cannot accurately assess the likely costs of the NHI unless it knows how many facilities and practitioners are likely to participate in it. Yet this vital issue remains entirely uncertain at present.

The 'pooling' concept and its likely ramifications

According to Dr Motsoaledi and Dr Humphrey Zokufa, managing director of the Board of Healthcare Funders, the proposed NHI system can easily be funded by 'pooling' all the health care money currently available in the public and private sectors, and various other funds. [*Business Day* 22 September 2016] The minister has said that 'the power of pooling means that we can afford to insure all our people', while Dr Zokufa agrees. 'At the moment, the health rand is fragmented,' said Dr Zokufa in September 2016. 'It is stretched between the nine provinces, the Road Accident Fund, Occupational Health, and 83 medical schemes. It is the role of the government to intervene here…and make sure that we pool the money for health care.' [*Business Day* 22 September 2016]

Treasury figures cited in the White Paper put budgeted spending on public health care at some R183bn in 2016/17. In the same period, total spending on private health care (mostly in the form of contributions to medical schemes) is expected to come in at R189bn. This gives a combined total of R372bn in the current financial year which could theoretically be made available to fund the NHI system.

Dr Zokufa also seems to think that monies in the Compensation Fund, coupled with those in the Road Accident Fund, could further swell the amount available for the NHI. But this overlooks the fact that the Compensation Fund, as earlier noted, faces a shortfall of more than R20bn in outstanding claims to some 400 000 mineworkers under Udimwa, and perhaps as much as R5bn on the 100 000 claims still to be settled under Coida (see above). In addition, the Road Accident Fund has long been insolvent and now has an unfunded liability of some R145bn, according to its most recent annual report. [*Legalbrief* 11 October 2016] This puts the combined outstanding liabilities of the two funds at roughly R170bn, which is almost the same as the total amount allocated for all public health expenditure in the 2016/17 budget.

The Compensation Fund and Road Accident Fund will thus drain the funds available for the NHI system, rather than contributing to them. The minister and Dr Zokufa also seem to assume that the government will easily be able to extract from a relatively small pool of taxpayers as much as they now voluntarily spend (some R189bn) on the effective and efficient private health care of their choice. The White Paper suggests that those who currently belong to medical schemes must be willing to do this as part of an essential social solidarity.

However, standards of health care are likely to go down once the government controls every aspect of the system: from the treatment protocols to be applied to the medicines and other

goods to be provided. In addition, demand for health services will expand so much that long delays in obtaining treatment are likely to become endemic.

The risks here are illustrated by experience in Canada, which has a universal health care system similar in some ways to what the NHI envisages. In Canada, waiting times have gone up significantly, according to a study conducted by the Fraser Institute in 2014. In general, waiting times for medically necessary treatment have increased from 9.3 weeks in 1993 to 18.2 weeks in 2014. Especially long wait times are experienced for hip, knee and back surgery (42.2 weeks) or neurosurgery (31.2 weeks). [*The Star* 4 February 2016]

However, efficient health care is vital to the middle class, both established and emerging. Many of the country's high earners, whose skills put them in demand in other countries too, could thus decide to emigrate instead. They will then not be available to contribute either to the NHI or to any of the government's other spending needs, from education to the social wage and public servant wages.

Emigration from within this group could also have major implications for South Africa's small tax base. According to the South African Revenue Service, some 57% of South Africa's personal income taxes are paid by about 480 000 high-earning individuals. If a mere 200 000 of them were to emigrate, this could cut South Africa's personal tax revenue by a quarter. This would create serious funding issues for the government in all categories of spending. [*Business Day* 15 August 2016]

Increased emigration could also have major implications for future economic growth. South Africa confronts a major skills shortage, which the failing school system has long proved unable to address. Hence, the emigration of even 200 000 highly skilled individuals would also have major impact on the skills base and the economy's capacity to grow. In addition, by the government's own admission, every R1 spent on healthcare creates 5c of extra economic activity in the long run. But the opposite, of course, is also likely to apply. The economic effect of *not* spending R189bn on private health care suggests that the economy could contract significantly, with GDP diminishing rather than expanding. [*Business Day* 15 August 2016]

Emigration among doctors and other health practitioners could also be fueled. The White Paper, as earlier noted, proposes that the same capitation fees should be paid to doctors and other health practitioners irrespective of whether they are working for the NHI in the public or the private sectors. But private practitioners must cover a host of overhead expenses from which public practitioners are shielded. Hence, the fees set by the NHI Fund could well be too low to cover individual practice costs. Writes Dr Serfontein: 'Inability to cover practice expenses under the NHI would lead to providers closing shop. With the public service not seen as a viable employment alternative, further emigrations could follow.' [*Business Day* 15 August 2016]

Long delays in paying doctors and other health practitioners could further encourage emigration. Again, in the words of Dr Serfontein, 'If the NHI Fund pays as efficiently as the Compensation Fund, waiting 70 days for payment would not help to keep practices operating either.' [*Business Day* 15 August 2016] Again, many practitioners may respond by deciding to emigrate.

Other job losses are also likely. At present, South Africa's 83 medical schemes and their administrators employ a large number of skilled individuals. Under the NHI, however, few medical schemes will be able to survive as medical schemes will then be confined to offering 'complementary cover to fill gaps in the universal entitlements offered by the state'. [Para 399, White Paper] A medical scheme might, for example, undertake to cover a rare disease (such as haemophilia) as this would probably not be included in the NHI package. However, the pool of potential members wanting such cover would be very small, while premiums would have to be very high. [Serfontein, FMF presentation, 20 April 2016] Most medical schemes will close down in these circumstances, as the White Paper seems also to acknowledge.

In addition, 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 stresses, 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]

As medical schemes are forced to close down under the NHI system, so the large number of administrators currently employed in the industry will be pushed out of their jobs. This will add to unemployment, reduce the revenues available to the state, and constrain economic growth. [*Business Day* 15 August 2016]

For all these reasons, the pooling principle will not suffice as a funding mechanism for the NHI. Nor will the pooling principle bring down the costs of health services, as the minister has also claimed.

Writing in the *Sunday Times* in June 2016, Dr Motsoaledi said the country had 'managed to make HIV/AIDS care more affordable by combining all South Africans into one purchasing pool'. The minister went on: 'Back [in 2002], it used to cost almost R10 000 per person to buy first-line drugs to treat someone with HIV/AIDS. Today it costs the government R1 728 per person per year.' [Sunday Times 26 June 2016]

However, this comparison is flawed in various ways. Economies of scale have helped to bring down unit costs, as ARV treatment has increased to cover some 3.4 million people. [*Mail & Guardian* 22 July 2016] In addition, pharmaceutical companies have come under enormous political pressure to make ARVs more affordable and have responded by sharply cutting prices. In addition, reduced costs are most easily achieved in industries that are not

labour-intensive, such as the manufacture of ARVs, whereas different considerations apply to the provision of health care.

This last point is captured in the notion of 'Baumol's cost disease', an economic theory that looks at how costs can be contained and points out that the cost of skilled labour is particularly difficult to reduce. Adds Dr Serfontein: 'Health-care provision…is labour-intensive, with costs linked tightly to the human resource component.' Pooling resources via the NHI Fund cannot overcome this problem. All NHI controls will do, as he points out, is to 'reduce how much health-care practitioners are paid until they can no longer cover their overhead costs and are forced to close their doors.' [*Business Day* 7 July 2016] At that point, as earlier noted, health practitioners are likely to emigrate, which will accelerate the brain-drain, reduce the tax base, and further hobble economic growth.

The White Paper's cost projections and funding proposals

If the pooling principle is applied, it would suggest (as earlier noted) that the costs of the NHI – assuming it were fully implemented in this financial year – would be R372 billion, as this is the combined total of projected public and private health care spending in 2016/17. [White Paper, Table 2, page 47] But the White Paper shies away from this number, instead suggesting that 'total NHI costs in 2025 will be R256bn (in 2010 terms)'. [Para 252, Table 1, Para 253, White Paper]

This projection is based on the assumption 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 come somewhere 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 White Paper's assumption that the economy will grow by 3.5% of GDP a year is based on the earlier Green Paper on the NHI. It thus overlooks the fact that a 3.5% growth rate was last attained in 2011. In 2014, the growth rate was down to 1.5% of GDP, while in 2015 it was down still further at 1.3% of GDP. In 2016, the growth rate is unlikely to exceed 0.4% of GDP and might be lower. The White Paper's belief that economic growth at 3.5% of GDP a year will help cushion the country from the rising costs of the NHI is thus deeply flawed.

The White Paper also assumes, in keeping with the pooling principle earlier described, 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. This figure is unrealistic. As earlier noted, NHI costs are likely to be far higher, while GDP is unlikely to grow at anything like 3.5% a year and could in fact contract if the economy falters further. Based on these flawed premises, the White Paper then assumes that this R79.1bn 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]

Given the obvious shortcomings in these figures, Econex, an economics consultancy, has remodelled them using more realistic economic growth projections, among other things. On this basis, it concludes that the revenue shortfall could well be R210bn in 2025. [Econex: Comments on select aspects of the NHI White Paper, Occasional note, June 2016] A shortfall of this magnitude cannot easily be bridged when the total yield from personal income tax in 2015/16 was roughly R392bn, while corporate taxes yielded some R189bn and VAT about R278bn. [*2016 Budget Review*, Summary, p iv]

Moreover, with the growth rate so low, with public debt having doubled to some R2 trillion since 2008, and with South Africa on negative watch for the downgrading of its sovereign debt to sub-investment or junk status, the country cannot afford to expand public spending in the way the NHI will inevitably require. In October 2016 the director general of the National Treasury, Lungisa Fuzile, reinforced this message, saying that 'South Africa's low economic growth, rising debt and depleted revenues are hurting the Treasury's capacity to close the country's large fiscal deficit'. He also warned that the government would 'have to introduce a range of cost-cutting measures to make up for poor economic growth'. [*Business Day* 13 October 2016]

The risk of being downgraded to junk status will also increase if the minister of finance, Pravin Gordhan, is unable to comply with the measures he promised in the February 2016 budget to bring the budget deficit down from 3.9% of GDP in 2015 to 3.2% in 2018. To this end, the minister has pledged to cut costs (particularly on the public service wage bill) and implement various new taxes to help augment revenue. But the tax burden is already high and there is little scope to increase it any further. In these circumstances, the government simply cannot afford to introduce the NHI system, the full costs of which are sure to be far higher than the White Paper suggests.

Probable NHI costs both now and in the future

Also important is the issue of how much the NHI is likely to cost over the next ten years, under the impact of consumer inflation and other factors. In nominal terms, expenditure on both public and private health care has gone up by roughly 45% over the past five years or by 9% a year on average. [White Paper, Table 2, page 47] It is unlikely that the rate of increase would be any lower in the future, especially with the rand so weak and inflation proving so difficult to tame.

Let us then assume that the NHI is introduced in full in the current financial year, at a conservative cost of R372bn (ie, the combined total of public and private health spending this year, in keeping with the pooling concept). From this base, the cost of the NHI is likely to rise by 45% to R539bn in 2021, and then by a further 45% to R782bn in 2026.

If the economy were to grow by 1.5% of GDP a year over this period (which may be too optimistic a forecast), then GDP in 2026 in basic prices would amount to some R4 630bn. On this basis, expenditure on the NHI would then amount to roughly 17% of GDP. Any such proportion is simply unaffordable.

It is also unlikely that medical inflation could be reduced through the price controls the NHI envisages. Medical inflation is inevitably higher than general consumer inflation, not only in South Africa but also elsewhere in the world. Many factors contribute to medical inflation and none of them can easily be countered.

Key cost drivers include increased utilisation, a growing burden of disease, an increasing number of older South Africans, the introduction of new medicines and medical technologies, increased labour costs, 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.

What this means, in short, is that the NHI will always be chronically under-funded, with the extent of under-funding increasing as time goes by and health care costs rise further. This is what has happened in other countries too, where the National Health Service in the United Kingdom confronts a major funding deficit. In practice, thus, people will have to wait longer and longer for any health services at all as costs rise and the number of health care practitioners diminishes.

Other economic variables

Other economic variables are important too. These range from the value of the rand to interest rates, the growing burden of public debt, and the increasing likelihood that South Africa may have its sovereign credit ratings downgraded.

On current trends, the value of the rand is likely to deteriorate in response to perceived political instability and a largely stagnant economy. Inflation will then go up, putting pressure

on the South African Reserve Bank to raise interest rates. Yet the interest on the government's debt is already substantial and has long been one of the fastest growing line items in the national budget. The interest burden will also grow greater still if the country is downgraded to junk status – a consequence which the adoption of the costly NHI system could also help to trigger.

Already, the government needs to reduce public spending, rather than expand it, if it is to avoid ratings downgrades. It nevertheless faces major pressure to provide free university education, and must at least increase the subsidies it pays to universities and poor students to cope with rising numbers at these institutions. Unless the economy begins to grow very much faster, the government will increasingly battle to find the revenue to finance its existing obligations – let alone new ones, such as the NHI.

Better alternatives available

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, 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 R182bn 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, which could help push many private health professionals out of the country, 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 is likely to 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 would 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.

South African Institute of Race Relations NPC **14th October 2016**