Free Market Foundation Submission

National Department of Health

National Health Insurance Bill

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Website: www.freemarketfoundation.com
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About the Free Market Foundation

The Free Market Foundation is an independent public benefit organisation founded in 1975 to promote and foster an open society, the rule of law, personal liberty, and economic and press freedom as fundamental components of its advocacy of human rights and democracy based on classical liberal principles. It is financed by membership subscriptions, donations and sponsorships.

Executive Summary

On 21 June 2018, the South African government gazetted the National Health Insurance (NHI) Bill. However, South Africans are no closer to understanding critical details such as how much the scheme will cost, where the money to pay for it will come from, and where the country will obtain the additional personnel (both medical and bureaucratic) to staff the ambitious scheme.

When one considers the high levels of poverty and unemployment, the small tax base, and the poor performance of the public health sector, it is difficult to envision how a government-funded system that promises "free healthcare for all" is appropriate for South Africa. The consequences of the NHI proposal are entirely predictable. It would reduce the quantity and quality of South African healthcare provision; drive more healthcare professionals out of the country; create a bureaucracy entirely incapable of efficiently handling the huge volume of claims; and impose an unnecessary and intolerable burden on both government and taxpayers.

It is neither necessary nor appropriate for government to provide "free healthcare for all". Those who can pay for their own healthcare and, generally, do not rely on government provided services, must be allowed to continue to do so. The proposed mandatory payments into the central NHI Fund, however, will crowd out private voluntary insurance. Cash-strapped individuals will no longer be able to afford their voluntary private-insurance premiums when burdened with a mandatory NHI payment as well. Those unable to pay both premiums will be forced to use the already overstretched public health service.

Government's role should be to fund the healthcare needs of only the poorest and most vulnerable members of society and allow the private healthcare sector to grow, innovate and expand. Such a healthcare model would not only be good for South Africa's financial health but would lead to better health outcomes for the poor.

The constitutionality of the Bill is also in serious doubt, in light of its flagrant disregard for the imperative of the Rule of Law as contained in section 1(c) of the Constitution. The Bill vests unrestrained, and sometimes completely unlimited, powers in the hands of government officials, in the form of discretionary and even law-making authority.

Introduction and Background

"The curious task of economics is to demonstrate to men how little they really know about what they imagine the can design"

Friedrich Hayek, The Fatal Conceit: The Errors of Socialism

The National Department of Health (NDOH) published the National Health Insurance (NHI) Bill on 21 June 2018 and has invited interested persons to submit comments on the NHI Bill. The Free Market Foundation (FMF) welcomes the opportunity to participate and provide input in this critical debate.

The FMF is dedicated to promoting a sound economic policy approach to the provision and funding of health care. The FMF maintains that the private supply of competitive health care services and the incremental extension of private funding is the most effective method of supplying high quality health care to the entire South African population.

The FMF urges government to devote its limited health budget to the supply of services to the poor, to purchase an increasing percentage of those services from private providers, and to allow and encourage the rapid growth of the private healthcare sector, thus enabling it to provide services to an increasing percentage of the population.

"It is amazing that people who think we cannot afford to pay for doctors, hospitals, and medication somehow think that we can afford to pay for doctors, hospitals, medication and a government bureaucracy to administer it."

Thomas Sowell, Professor of Economics: Senior Fellow at the Hoover Institution, Stanford University.

This submission demonstrates that the consequences of adopting the proposed National Health Insurance (NHI) scheme are entirely predictable. We believe that it is neither necessary nor appropriate for government to provide "free healthcare for all" because doing so would not make good use of scarce taxpayer resources. Having taxpayers fund healthcare for those who cannot afford it is one thing, but to insist on interfering in the arrangements of those who can afford it, is counter-productive and unnecessary.

The proposed National Health Insurance (NHI) will:

- Reduce the quality of healthcare provision;
- Drive more healthcare professionals out of the country;
- Create a bureaucracy entirely incapable of handling the huge volume of claims; and
- Impose an unnecessary and intolerable burden on both government and taxpayers.

We are concerned that despite the fact that the government has been working on its proposed healthcare plan for almost a decade, South Africans are no closer to understanding any of the material details of the proposed NHI including, but not limited to: how much the proposed scheme will cost; where the funding to finance the scheme will come from; and where we will obtain the additional personnel (both medical and bureaucratic) to staff the ambitious proposal. Yet government appears to be going ahead with the NHI scheme, and, in fact, is now in the second phase of implementation of the project. Given the conspicuous absence of the material details underlying the proposed scheme, we are concerned that this is a politically motivated event that will not materially improve the health outcomes of the poorest and most vulnerable members of society and may do more harm than good.

"Our fear is that the proposed NHI will fail to meet the expectations of the poor, will leave medical scheme members (including the working poor) worse off, will be massively expensive or even completely fiscally unaffordable, and will require far more doctors and nurses than are available. The danger is that it could well become a highly costly failure that will further increase frustration with service delivery."[1]

Professors Servaas van der Berg and Heather McLeod

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[1] Van der Berg, S. and Heather McCleod (2009) Crude NHI plan threatens to make a bad situation worse. Business Day. Available at: http://www.bdlive.co.za/articles/2009/09/04/crude-nhi-plan-threatens-to-make-a-bad-situation-worse

The Constitution

The Constitution contains various provisions, especially in the Bill of Rights, that protect the freedom of South Africans to determine their own destinies. This can be summed up in the notion of freedom of choice, or freedom of enterprise.

The most important provision underlying all of the other provisions is found in section 1 of the Constitution – the Founding Provisions. Section 1(a) provides that South Africa is founded on "[h]uman dignity, the achievement of equality and the advancement of human rights **and freedoms**" (our emphasis). This provision permeates all the provisions of the Bill of Rights by virtue of being a founding value.

Other provisions relevant to freedom of choice include the following:

- Section 7(1) provides that the Bill of Rights "enshrines the rights of all people in our country and affirms the democratic values of human dignity, equality and **freedom**" (our emphasis). Section 9(2) provides that the right to equality "includes the full and equal enjoyment of **all rights and freedoms**" (our emphasis).

- Section 10 provides that "[e]veryone has inherent dignity and the right to have their dignity respected and protected". According to the Department of Justice and Correctional Services, this means that "[n]o person should be perceived or treated merely as instruments or objects of the will of others. Every person is entitled to equal concern and to equal respect".[2]

- Section 12(1)(a) provides that everyone has the right "not to be deprived of freedom arbitrarily or without **just** cause" and section 12(1)(c) guarantees the right of everyone "to be free from all forms of violence from **either public or private sources**" (our emphasis).

- Section 13 prohibits "slavery, servitude or forced labour", the converse of which will also be true: forced unemployment or labour disassociation.

- Section 14 guarantees the right to privacy, meaning private affairs should not be interfered with or monitored without consent.

- Section 18 provides that "[e]veryone has the right to freedom of association". This right means that natural or juristic persons may associate or disassociate with whomever they wish and cannot be forced by law or other coercive means to associate or disassociate.

- Section 22 provides that all citizens have "the right to choose their trade, occupation or profession freely. The practice of a trade, occupation or profession may be regulated by law". The language of the provision is clear, in that the *practice*, but not the *choice*, of profession may be *regulated,* but not *prohibited*. To read prohibition into regulation would make the entirety of the provision and the 'right' redundant. No provision in the Constitution may be construed as being redundant or inconsequential.

[2] http://www.justice.gov.za/brochure/2014_ConstitutionRights.pdf/.

With reference to healthcare specifically, section 27(a) of the Constitution provides that, "Everyone has the right to have access to health care services, including reproductive health care". This, read with the above, clearly implies that South Africans have the right to freely choose their healthcare service providers and services. While the State is obliged in section 27(2) to "take reasonable legislative and other measures … to achieve the progressive realisation of [this right]", this provision cannot be read to mean the State may in the process violate the freedom of South Africans to exercise, on their own, their right to access to healthcare.

Chapter 2 of the Constitution – the Bill of Rights – does not 'create' rights, but merely protects pre-existing rights from infringement. Section 7(1) states that the Bill of Rights "enshrines" the rights, not creates them. Enshrining something, in the constitutional sense, means to place that thing somewhere where it is protected, in this case, in a constitution.[3] South Africans have rights outside of the Constitution, and if a provision in the Bill of Rights is repealed, that does not mean South Africans 'lose' that right. If this were the case, there would be little use in referring to rights as 'human' rights, as section 1 and the Preamble of the Constitution do. South Africans are all rights-bearing entities because we are humans with dignity and individuality, not because government has 'given' us those rights.

The rights in the Bill of Rights can be limited by operation of section 36, but the basic essence of the right in question must remain. Indeed, if protection for human rights is removed from the Constitution or otherwise perverted through legislative 'limitation', South Africa's constitutional project will be severely undermined in that the highest law will continue to recognise the rights in question, but will not adequately protect them. This is not a situation South Africans would want to find themselves in. By implying that government can extinguish rights simply by enacting legislation dressed in the garb of 'protecting' the people while undermining their freedom, the impression is created that rights are an idea owned by the State, and not the people. This would be faulty both according to human rights theory, but also according to the logic of the Constitution itself.

The Rule of Law

Section 1(c) of the Constitution provides that South Africa is founded upon the supremacy of the Constitution and the Rule of Law. Section 2 provides that any law or conduct that does not accord with this reality is invalid. This co-equal supremacy between the text of the Constitution and the doctrine of the Rule of Law remains underemphasised in South African jurisprudence, but it is important to note for the purposes of this submission.

The FMF's Rule of Law Project's Board of Advisors formulated the following ten Imperatives of the Rule of Law:

> **1st Imperative:** All law must be clear, predictable, accessible, not contradictory, and shall not have retrospective effect.
>
> **2nd Imperative:** All legislation that makes provision for discretionary powers, must also incorporate the objective criteria by which those powers are to be exercised. The enabling legislation must, in addition, stipulate the purpose or purposes for which the powers may be exercised.

[3] https://dictionary.cambridge.org/dictionary/english/enshrine.

3rd Imperative: All law must apply the principle of equality before the law.

4th Imperative: All law must be applied fairly, impartially, and without fear, favour or prejudice.

5th Imperative: The sole legitimate authority for making substantive law rests with the legislature, which authority shall not be delegated to any other entity.

6th Imperative: No law shall have the aim or the effect of circumventing the final authority of the courts.

7th Imperative: No one may be deprived of or have their property expropriated, except if done with due process for the public interest, and in exchange for compensation that is just and market-related.

8th Imperative: The law shall afford adequate protection of classical individual rights.

9th Imperative: All law must comply with the overriding principle of reasonableness, which comprehends rationality, proportionality, and effectiveness.

10th Imperative: The legislature and organs of state shall observe due process in the rational exercise of their authority.

One of the Constitutional Court's most comprehensive descriptions of what the Rule of Law means was in the case of *Van der Walt v Metcash Trading Ltd*. In that case, Madala J said the following:

> "[65] The doctrine of the rule of law is a fundamental postulate of our constitutional structure. This is not only explicitly stated in section 1 of the Constitution but it permeates the entire Constitution. The rule of law has as some of its basic tenets:
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> > 1. the absence of arbitrary power – which encompasses the view that no person in authority enjoys wide unlimited discretionary or arbitrary powers;
> > 2. equality before the law – which means that every person, whatever his/her station in life is subject to the ordinary law and jurisdiction of the ordinary courts.
> > 3. the legal protection of certain basic human rights.
>
> [66] The concept of the rule of law has no fixed connotation but its broad sweep and emphasis is on the absence of arbitrary power. In the Indian context Justice Bhagwati stated that:
>
> > 'the rule of law excludes arbitrariness and unreasonableness.'
>
> We would also add that it excludes unpredictability. In the present case that unpredictability shows clearly in the fact that different outcomes resulted from an equal application of the law."[4]

[4] *Van der Walt v Metcash Trading Ltd* 2002 (4) SA 317 (CC) at paras 65-66. Citations omitted.

The Rule of Law thus:

- Permeates the entire Constitution.
- Prohibits unlimited arbitrary or discretionary powers.
- Requires equality before the law.
- Excludes arbitrariness and unreasonableness.
- Excludes unpredictability.

The Good Law Project's *Principles of Good Law* report largely echoed this, saying:

> "The rule of law requires that laws should be certain, ascertainable in advance, predictable, unambiguous, not retrospective, not subject to constant change, and applied equally without unjustified differentiation."[5]

The report also identifies four threats to the Rule of Law,[6] the most relevant of which, for purposes of this submission, is the following:

> "[The Rule of Law is threatened] when laws are such that it is impossible to comply with them, and so are applied by **arbitrary discretion** […]"

Friedrich Hayek wrote:

> "The ultimate legislator can never limit his own powers by law, because he can always abrogate any law he has made. The rule of law is therefore not a rule of the law, but a rule concerning what the law ought to be, a meta-legal doctrine or a political ideal." [7]

What is profound in Von Hayek's quote is that he points out that *the* Rule of Law is not the same as *a* rule of *the* law. Indeed, any new Act of Parliament or municipal by-law creates and repeals multiple 'rules of law' on a regular basis – expropriation without compensation would be an example of 'a' rule of 'the' law. The Rule of Law is a doctrine, which, as the Constitutional Court implied in *Van der Walt*, permeates all law, including the Constitution itself.

Albert Venn Dicey, known for his *Introduction to the Study of the Law of the Constitution*, and considered a father of the concept of the Rule of Law, wrote that the Rule of Law is "the absolute supremacy or predominance of regular law as opposed to the influence of arbitrary power, and excludes the existence of arbitrariness, of prerogative, or even wide discretionary authority on the part of the government".[8]

Dicey writes "the rule of law is contrasted with every system of government based on the exercise by persons in authority of wide, arbitrary, or discretionary powers of constraint".[9] He continues, saying the Rule of Law means "the absolute supremacy or predominance of regular law as opposed to the

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5 Good Law Project. *Principles of Good Law.* (2015). 14.
6 Good Law Project 29.
7 Von Hayek FA. *The Constitution of Liberty.* (1960). 206.
8 Dicey AV. *Introduction to the Study of the Law of the Constitution.* (1959, 10th edition). 202-203.
9 Dicey 184.

influence of arbitrary power, and excludes the existence of arbitrariness, of prerogative, or even of wide discretionary authority on the part of the government".[10]

The opposition to arbitrary power should not be construed as opposition to discretion in and of itself. Officials use discretion to determine which rules to apply to which situation, and thus some discretionary power is a natural consequence of any system of legal rules. However, the discretion must be exercised per criteria which accord with the principles of the Rule of Law, and the decision itself must also accord with those principles.

A common example of arbitrary discretion is when a statute or regulation empowers an official to make a decision "in the public interest". What is and what is not "in the public interest" is a topic of much debate, and empowering officials to apply the force of law in such a manner bestows upon them near-absolute room for arbitrariness. The "public interest", however, can be one criterion among other, more specific and unambiguous criteria.

The fact that some discretion should be allowed is a truism; however, the principle that officials may not make decisions of a substantive nature still applies. Any decision by an official must be of an enforcement nature, i.e. they must do what the legislation *substantively* requires. For instance, an official cannot impose a sectoral minimum wage. The determination of a minimum wage is properly a legislative responsibility because it is of a substantive nature rather than mere enforcement. Unfortunately, the Basic Conditions of Employment Act gives the Minister of Labour the authority to make "sectoral determinations" – which includes determining a minimum wage – which is a clear violation of the Rule of Law and the separation of powers.[11]

Legal Matters Relating to the National Health Insurance Bill

Clause 10(3)(b) of the NHI Bill provides that the NHI Fund will not cover treatment costs if a healthcare practitioner is unable to reasonably demonstrate that "no cost-effective intervention exists for the [treatment] service". The implications of this clause are severe. Because "cost-effective" is not defined, it could be that, in the opinion of a healthcare practitioner, there is a treatment available for some illness, but it is not cost-effective, and thus the NHI will not fund it. For the indigent, and for those who have been deprived of their private medical scheme cover and forced onto the NHI, this could prove fatal. The lack of definition is a violation of the Rule of Law imperative that the law must be clear, and with the imperative that the law must be reasonable. We submit that clause 10(3)(b) be excised from the Bill, or that a proper definition for "cost-effective" be provided.

Clause 11(3) provides that the Benefits Advisory Committee "must determine the health service benefits contemplated in subsection (1)", which, in turn, provides that "comprehensive health service benefits must be purchased by the Fund, for the benefit of users who are registered with the Fund". This clause contains no criteria to guide the committee in making its determination, meaning that the committee can determine a package of benefits arbitrarily with no reference to the reality of the healthcare needs of society. We submit that the health service benefits package be spelled out in the NHI Bill itself.

10 Dicey 198.

11 Section 51 of the Basic Conditions of Employment Act (75 of 1997).

Clause 13 provides that the Board of the NHI Fund will be independent, but clause 14(1) provides that the members of the Board are to be "recommended by the Minister and appointed by Cabinet". It follows that the members are not independent of the Minister or government if it is appointed by the Minister or government. We submit that the Board must instead be chosen by an association of private healthcare practitioners.

Clause 38(2)(b) provides that, in order to be accredited, a health service provider must *inter alia* "meet the needs of users". The notion of the "needs of users" is highly subjective and presumably, highly transient. It would be absurd to, in terms of clause 38(7), allow service providers to be deprived of their accreditation because the "needs of users" have recently changed and, for instance, they have not adapted quickly enough. One of the benefits of the private as opposed to the public sector is competition and the pressures of market forces, meaning that consumers can choose which service providers they prefer. Some service providers will work differently from others. The "needs of users" will never be the same from one service provider to another, and how they react to change will similarly be different. Making it a provision of law that a service provider can only be accredited, and can only hold on to accreditation, if they "met the needs of users", is unfair, inequitable, and will lead to absurdities. We submit that this provision be removed from the Bill.

Clause 38(7)(j) provides that the NHI Fund may withdraw or not renew accreditation if a service provider "infringes any code of ethics or law applicable in the Republic". The problem with this provision should be self-evident. There are hundreds, if not tens of thousands, of differing "codes of ethics" in South Africa applicable to different sectors, businesses, or even individual departments within businesses. The FMF itself has a code of ethics. The provision says, "any code of ethics … applicable in the Republic", which jurisprudentially means any code of ethics whatsoever. As a result, if a health service provider does not comply with the FMF's code of ethics, which is applicable in the Republic, it stands to lose accreditation. We submit that this provision should be changed to refer only to law and those codes of ethics the service providers by law are required to comply with.

Clause 39(2) provides that, in the case of specialist and hospital services, service providers will be paid *inter alia* based on performance. This provision is not tempered by any criteria nor a definition of what "performance" means in this context. It appears to be implied that the NHI Fund will not pay, or will pay below market price, when it (or, presumably, the users – this too is left undefined) is dissatisfied or otherwise unhappy with the "performance" of the provider. It should be obvious how a provision of this nature can be abused. It is also unclear who the aggrieved party must be, the Fund or the user. This provision is a violation of the Rule of Law imperatives that the law must be clear and predictable. We submit that this provision must be excised from the Bill.

Clause 52 is problematic as a whole. None of the Minister's regulation-making powers are constrained by criteria, meaning the Minister can effectively rule by diktat. Clause 52(1)(zB)-(zD) are especially problematic as they provide the Minister with the power to make regulations on practically any other matter not mentioned in the foregoing subclauses, without restraint. This violates the Rule of Law imperatives that the law must be predictable, that legislation which provides for discretionary powers must incorporate criteria and for which specific purposes the powers may be exercised, and that the sole legitimate authority for making substantive law rests with the legislature and not the executive. We submit that clause 52 as a whole be excised or be guided by criteria providing for reasonableness, rationality, effectiveness, and proportionality.

Is National Health Insurance the Appropriate Vehicle to Achieve Universal Health Coverage?

The FMF supports the notion of Universal Health Coverage (UHC) and agrees that all South Africans should have some form of health insurance. However, we question the validity of government attempting to provide "free healthcare for all". A better aim would be to determine the best way to increase access to quality healthcare for the poor. More specifically, we believe that government should use the same framework that it applies to other constitutionally mandated objectives such as housing and education, where the state cares for the indigent and leaves the voluntary private market alone. To minimise the state's responsibility, the private sector should be deregulated while government concentrates on using scarce taxpayer resources to pay the premiums for the poor, rather than trying to insure the entire nation.

Even advanced, developed countries are struggling to meet the healthcare demands of their citizens under their "free healthcare for all" systems. Indeed, ample evidence exists of how government involvement in healthcare increases costs, erodes quality, and thwarts innovation. For example, a 2017 study entitled: *Waiting Your Turn – Wait times for health care in Canada* by the Fraser Institute found that wait times for medically necessary treatment in Canada have increased from 9.3 weeks in 1993 to 20.0 weeks in 2016. Especially long wait times were experienced for orthopaedic surgery (41.7 weeks), neurosurgery (32.9 weeks) and ophthalmology (31.4 weeks).[12]

The estimated cost of waiting for care in Canada for patients who were in the queue in 2017, according to calculations based on the methodology produced by Globerman and Hoye (1990), was an estimated CAD1.9 billion[13] (approximately R21.9 billion) – an average of about CAD1,822 (R20,980) for each of the estimated 1,040,791 Canadians waiting for treatment in 2017. Alternatively, that cost works out to roughly CAD13,803 (R158,942) for each individual among the 13.2% percent of patients in the queue who were suffering considerable hardship while waiting for care. Moreover, this estimate only counts costs that are borne by the individual waiting for treatment. The costs of care provided by family members (in time spent caring for the individual waiting for treatment) and their lost productivity due to difficulty or mental anguish, are not valued in this estimate.[14]

Canadian courts have seen the evidence and ruled that Canada's single payer health insurance monopoly makes people wait too long to get medically necessary care. The Canadian single payer system is an example of what not to do in health care. The fact is that single payer systems are probably the worst way to achieve Universal Health Coverage (UHC). If Canada is currently witnessing the failure of its own single payer health insurance system, why would South Africa want to adopt such a system?

Many Canadian trained and previously active physicians have left Canada for better opportunities and working conditions in the United States. In contrast, American doctors are not voting with their feet by moving to Canada for better opportunities or working conditions. According to the Fraser Institute, as of 2002, there were 8,990 Canadian-trained physicians (a number equal to 13 percent of the

[12] Fraser Institute (2017) Waiting Your Turn – Wait times for health care in Canada. Available at: https://www.fraserinstitute.org/studies/waiting-your-turn-wait-times-for-health-care-in-canada-2017
[13] CAD = Canadian Dollars. A the time of writing CAD1 = R11.52
[14] Fraser Institute (2016) The Private Cost of Public Queues for Medically Necessary Care, 2016 edition. Available at: https://www.fraserinstitute.org/sites/default/files/private-cost-of-public-queues-for-medically-necessary-care-2016.pdf

Canadian physician workforce) actively practising in the United States. By contrast, only 519 American-trained physicians (equal to less than 1 percent of the American physician workforce) were working in Canada.[15]

Under single payer models, governments inevitably impose price controls that limit the supply of medicines and access to treatment because they simply are not able to provide unlimited care to everyone. The slow and bureaucratic nature of government prevents new technologies from entering the system. Procedures are limited, as are the number of hospitals and the number of beds in those hospitals. This causes increased waiting times, or millions being treated with outdated medical technologies. Evidence from the Fraser Institute study indicates that government control over hospital financing results in the capital deterioration of the facilities.

According to the Fraser Institute, "Canadians do not get good value for money from their health system. There are many hidden costs in Canadian health care that are ignored by advocates of single-payer systems. On a comparable basis, Canadians have fewer doctors and less high-tech equipment than Americans. Canadians also have older hospitals and have access to fewer advanced medicines than Americans… If Canadians had access to the same quality and quantity of health care resources that American patients enjoy, the government health insurance monopoly in Canada would cost a lot more than it currently does. Not only do Canadians have fewer health care resources than Americans, experience also shows that the Canadian health system is not financially sustainable in the long run".[16]

Canada is not the only advanced country that is struggling to meet the healthcare demands of its citizens. The British National Health Service (NHS) is often held up as an example of egalitarian healthcare, funded through general taxation and free at the point of use. However, it has demonstrated all the flaws that might be expected from a state monopoly: waste, inefficiency, under-investment, rationing and constant political interference. The result has been poor health outcomes for British citizens compared with other wealthy countries, and a failure by the NHS to live up to its founding principles of comprehensive, unlimited healthcare and egalitarianism.

Indeed, a headline in *The Guardian* stated, "[Britain's] NHS is in trouble and its chief executive has requested £8bn to save it".[17] Moreover, *The Guardian* states, in the NHS's efforts to cut costs "the savings have been accompanied by a substantial decline in quality – as revealed by treatment waiting time targets…there is growing evidence that, even in the parts of the country supposed to be leading the way, there are often insurmountable difficulties in trying to change the way NHS works".[18] *The Guardian* goes on to note that, "A big part of the problem is that the central bodies have provided virtually no support in clearing obstructions out of the way nationally to enable local changes to take place… Everyone agrees what needs to change, the central bodies are far too slow in enabling change to happen, the case for change becomes ever more urgent as finances deteriorate, then that deterioration forces ever greater focus on short-term cash savings rather than long-term transformation of care".[19]

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[15] Fraser Institute (2008) The Hidden Costs of Single Payer Health Insurance. Available at: https://www.fraserinstitute.org/sites/default/files/HiddenCostsSinglePayer.pdf

[16] ibid

[17] http://www.theguardian.com/society/2014/oct/29/how-sick-are-worlds-healthcare-systems-nhs-china-india-us-germany

[18] http://www.theguardian.com/healthcare-network/2016/may/13/the-nhs-cannot-escape-its-financial-crisis-without-more-money

[19] http://www.theguardian.com/healthcare-network/2016/may/13/the-nhs-cannot-escape-its-financial-crisis-without-more-money

To correct the problems associated with government-run national health systems; the British NHS system is adopting several reforms where the private sector will play an increasing role in both financing and delivery of health care. In her paper entitled "NHS as State Failure: Lessons from the Reality of Nationalised Health Care", published in the December 2008 issue of *Economic Affairs*, Helen Evans, the Director of Nurses for Reform in the UK, notes, "Under the general rubric of Public Private Partnerships, the British government has championed a whole raft of market-oriented reforms".[20]

These reforms include sending NHS patients to independent hospitals and clinics for care; asking the private sector to design, build and operate a new generation of Independent Sector Treatment Centres for the benefit of NHS patients, and a plan to establish a new generation of Independent Foundation hospitals free from government control with a greater say over how they develop and raise capital. More importantly, an increasing number of British people are taking responsibility for their own health care. Approximately 7-million individuals have private medical insurance; 6-million have private health cash plans; 8-million pay privately for complementary therapies, and, each year, more than 250,000 pay for their own acute surgery.

In a welcome change to past legislation, seriously ill patients are now allowed to add their own money to the purchase of the most innovative medicines and treatments. Evans states, "Only by putting patients and consumers' interests first will healthcare really improve. It is only when healthcare is opened up to real consumers, trusted brands and new funding mechanisms – such as private health savings accounts – that nurses and other health professionals will find themselves working in environments with the incentives, resources and freedom to deliver responsive, popular and high quality care".[21] Evans concludes her paper by stating, "As such, I reject egalitarianism and nationalisation in favour of healthy privatisation and competition. Ultimately, 20 years working in the NHS has taught me to believe in people and markets – not political diktat".[22]

If advanced developed countries such as Canada and Britain, which have gross domestic products per capita that are more than three times greater than South Africa's, are struggling to meet the demands of patients under their "free health care for all" policies, it is unrealistic to assume that South Africa will be able to afford to do so. The government may be able to shift costs, but it can never avoid them. If it introduces a policy of forcing Peter to pay for Paul's medical care and Paul to pay for Peter's, while Peter and Paul may be tricked into thinking that someone else is paying and that they are receiving "free" medical care, the reality is that neither one of them is receiving free healthcare. Ultimately, under the misguided belief that they are receiving free health care, both Peter and Paul will be encouraged to over-utilise it and neither of them will take responsibility for their own medical care requirements. This is why, whenever possible, we should favour systems that encourage individuals to decide for themselves where and how to spend their hard-earned cash.

[20] Evans, H. (2008) NHS as State Failure: Lessons from the Reality of Nationalised Healthcare. Restricted access available at: http://onlinelibrary.wiley.com/doi/10.1111/j.1468-0270.2008.00870.x/abstract
[21] ibid
[22] ibid

Financing of National Health Insurance

We note with some concern the lack of any comprehensive costing exercise of the NHI proposal or what the impact would be on taxpayers and the economy.

This is exacerbated by an absence of any clear position on what services will be contained within the NHI benefit package and the widely publicised admission by the Minister of Health that the 2010 cost projection contained in the green and white papers was an estimation.

The green and white papers that have led to the draft NHI Bill have also lent upon misquoted commentary by the WHO that the costs involved in achieving UHC are unimportant – both papers stated further that cost consideration of NHI is "the wrong approach". The WHO is clear that costings and the associated assumptions are important in guiding policy matters and it is very clear that the NHI Bill represents a substantial change in the country's health policy.

In terms of guiding policy matters, it is also of concern that no alternatives to NHI have been proposed or costed. It remains the sole policy position of government with no consideration of alternatives.

Our concerns on the cost of the NHI are summarised in the following key points:

- The only costing estimate that has been utilised is now 8 years old – given the time elapsed and that the estimates of economic growth that were relied upon in both the green and white papers have not materialised, this should be discarded and replaced with a more up-to-date and substantively more comprehensive costing analysis.

- Alternative models should also be considered and costed.

- The assumption that the current private spend by consumers on medical scheme contributions would be available for funding of the NHI is unrealistic. Contributions to medical schemes and out-of-pocket spend are discretionary private spend not available to any NHI funding pool. This effectively means that the NHI will be entirely tax funded.

- Understanding the cost implications of funding the NHI is a cornerstone of the entire policy. The implementation potential of NHI rests on a few key principles, of which cost to taxpayers and the economy are an indispensable attribute.

- The administrative costs of NHI, including those of addressing the capacity requirements of the Office of Health Standards Compliance (OHSC), have also not been considered. This cost consideration does not even consider if sufficient personnel exist to address the obviously greater capacity required for the OHSC under NHI.

Our view on the aspect of cost is that SA does not have the fiscal wherewithal to fund as ambitious a policy as NHI. The green and white papers drew comparisons with other developing countries that have achieved some degree of success with national health systems (for example Thailand, Mexico, Brazil, etc) but, whilst these are also recognised as developing economies, they are fundamentally different to South Africa.

Their tax bases are orders of magnitude greater than ours and conversely their unemployment rates are a small fraction of ours. This provides these economies with greater means to offer publicly funded healthcare, yet even with much greater means, countries with government operated single-payer models, draw overall from several sources including co-payments, out-of-pocket payments and privately pre-funded health insurance.

These realities mean that the most effective manner for South Africa to achieve UHC is to promote an effective, efficient and expansive private sector to alleviate the burden on the state of providing the bulk of healthcare services.

Ireland, with substantially superior key economic indicators than SA, came to the realisation in 2015 that their country could not afford to implement their proposed Universal Healthcare Insurance model. After a costing analysis was done of the proposals contained in Irelands 2011 White Paper, the Irish government scrapped the proposal, declaring it unaffordable.

We believe that to achieve effective UHC, substantial reform of the private sector and strengthening of the public sector is required. Reforms to the private sector are discussed in the next section.

The challenges in the public sector are well known, vis-à-vis substantive press coverage as well as the current work undertaken by the OHSC. Suffice to say that government must be aware of what it is required to undertake to reform and strengthen the public sector, we have not discussed this further in this document.

The Role of the Private Sector in Achieving Universal Health Coverage

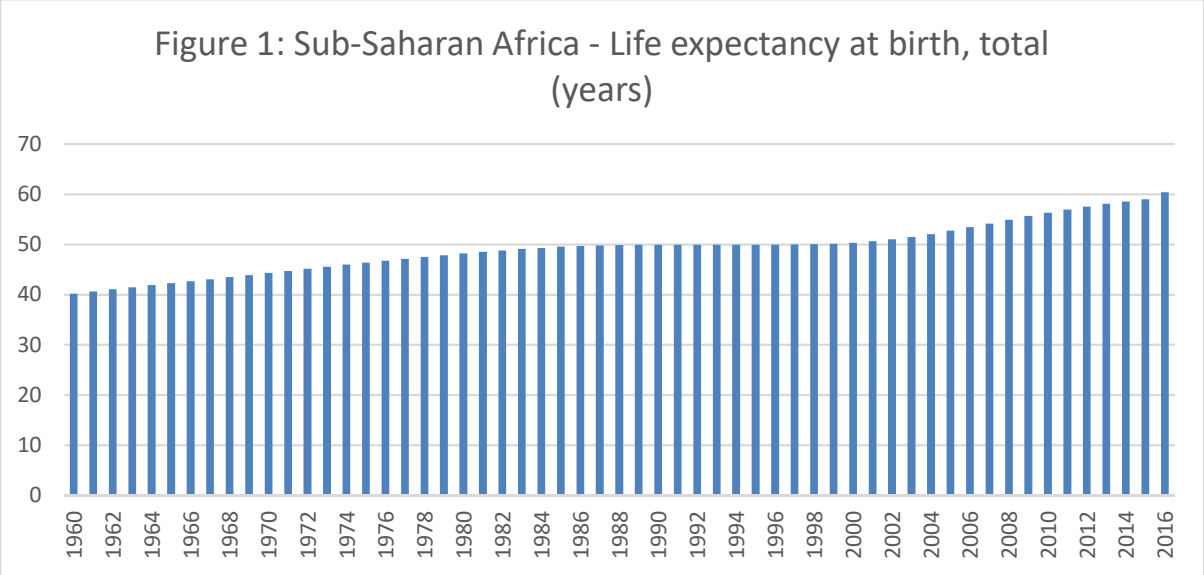
The World Health Organization (WHO) defines Universal Health Coverage (UHC) as "Ensuring that all people have access to needed promotive, preventive, curative and rehabilitative health services, of sufficient quality to be effective, while also ensuring that people do not suffer financial hardship when paying for these services. Universal health coverage has therefore become a major goal for health reform in many countries and a priority objective of WHO".[23] The WHO, however, does not prescribe how UHC is to be achieved.

The WHO recommends that countries should find ways to "pool funds,…so as to spread the financial risks of illness across the population" and avoid crippling health care costs for both the poor and the rich. But it also stresses that nations must choose the systems that suit them best – and that whatever option is adopted must be affordable in the long-term. The WHO further categorically states, "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".[24]

While local and international efforts have accelerated efforts towards UHC, today progress towards achieving UHC is elusive, especially in lower-income countries. The HIV crisis plaguing Africa in the 1980s and 1990s reversed healthcare achievements of earlier decades, stunting advancements in key

[23] World Health Organization (2017). Accessed: 27-07-2017. URL: http://www.who.int/healthsystems/universal_health_coverage/en/
[24] World Health Organization (2017) Accessed: 27-07-2017. URL: http://www.who.int/mediacentre/factsheets/fs395/en/

health indicators. For example, life expectancy at birth in sub-Saharan Africa (SSA) stagnated at approximately 49 years over the period 1988-1996 after registering steady improvements over the course of the previous three decades. Since the late 1990s, though, life expectancy at birth in SSA has improved from 49 years in 1996 to 59 years in 2015 (see Figure 1 below)



Source: World Bank, World Development Indicators

Pervasive capacity constraints within healthcare systems in lower income countries have been recognised as a significant factor hindering success towards UHC. Without a sufficiently skilled human resource base and functioning infrastructure, no amount of money can guarantee effective care.[25,26]

Global organisations such as the United Nations Children's Fund (UNICEF), the World Bank, and the Rockefeller Foundation take the view that many countries will find it difficult to achieve UHC straightaway and should instead focus on a limited set of cost-effective interventions as the first step towards achieving the goals embedded in the Alma-Ata Declaration, which seeks to protect and promote the health of all people by increasing access to Primary Health Care (PHC) services.[27] This model involves significant private-sector participation and is prevalent within resource constrained health systems.[28]

However, there remains significant opposition to private sector involvement in healthcare, with Oxfam describing it as "unregulated, unaccountable and out of control".[29] But as Prof Dominic Montagu points out, "The idea that involving the private sector an antithetical is bizarre…more than two-thirds of all OECD countries rely mostly on private outpatient care and some of the best

[25] ibid
[26] Gillam, S (2008). Is the declaration of Alma Ata still relevant to primary healthcare? BMJ 336, 536–538.
[27] http://www.who.int/publications/almaata_declaration_en.pdf
[28] Stuckler, D, Feigl, AB, Basu, S & McKee, M (2010). The political economy of universal health coverage, in: Background Paper for the Global Symposium on Health Systems Research. Geneva: World Health Organization.
[29] Unregulated and unaccountable: how the private health care sector is India is putting women's lives at risk. URL https://www.oxfam.org/en/pressroom/pressreleases/2013-02-06/unregulated-and-unaccountable-how-private-health-care-sector

performing countries also deliver the majority of inpatient care through private hospitals".[30] Moreover, Prof Montagu states, "The private sector also provides up to 80% of healthcare in many developing countries".[31]

In the South African context, private health insurance provides the main vehicle for accessing private healthcare services and given the significant amount of financial and human resources located within the private sector, the continuation and expansion of this sector is of vital importance to South Africa's overall health and welfare.

The language of section 27 is not an impediment to a private sector-led achievement of UHC, and, as alluded to above, a reading of the Constitution as a whole would seem to imply that such private sector-led development as a result of the people's exercise of their constitutional freedom, is an imperative.

Private Medical Schemes and So-Called "Social Solidarity"

The fundamental problem yet to be openly identified, let alone resolved, is the principle of so-called "social solidarity" contained in the Medical Schemes Act of 1998 (MSA). The MSA ushered in four main amendments: open enrolment, community rating, statutory solvency requirements, and a comprehensive package of hospital and outpatient services that all schemes are compelled to provide regardless of the individual's age, sex or health status. This minimum package of benefits is commonly referred to as prescribed minimum benefits (PMBs). Each of these amendments resulted in an increase in the cost of providing medical scheme coverage, which invariably needed to be borne by the consumer. The MSA made it compulsory for every scheme to charge the same premium to every member within an option, despite their age or state of health, a practice commonly referred to as community rating.

The MSA also introduced statutory solvency requirements, which stipulate the minimum amount of accumulated funds that each scheme should hold as a reserve. Regulation 29 of the Act prescribes that the minimum accumulated funds of the medical schemes should be at least 25 per cent of gross annual contributions. This legislation was enacted to prevent a scheme from going insolvent should it experience an unusually high number of claims and record an operating loss in a particular period. But the formula for calculating the current solvency ratio was arbitrarily decided with no regard to the implications for the functioning of medical schemes. The solvency requirements were set at a level of 10 per cent when they were introduced in 2000 and have since been increased by incremental amounts to the current level of 25 per cent, which has been effective since 2004.

According to the Actuarial Society of South Africa, solvency is an asymptotic function of contribution increase. In other words, the higher the solvency requirement, the greater the increase required to improve solvency by 1 per cent. For example, increasing the solvency requirement from 10 per cent to 11 per cent requires a contribution increase of 1.39 per cent. However, increasing the solvency requirement from 24 per cent to 25 per cent requires an increase of 2.07 per cent in contributions.

[30] Universal health coverage and private hospitals are not mutually exclusive. URL: https://www.theguardian.com/global-development/2015/may/18/universal-health-coverage-private-sector-world-health-organisation

[31] ibid

Increasing the solvency requirement drives up membership contributions disproportionately and this negatively affects the rate of increase in the number of members entering a scheme.

A scheme that has reserves below the legislated 25 per cent minimum requirement will have trouble 'catching up' because new members will be in the invidious position of having to contribute not only towards their own portion of the required reserves, but also towards making up past shortfalls, a cost for which they will receive no benefit. Despite the intentions of the SA government to prevent schemes from failing, the solvency requirements increase contributions, which, in turn have adversely affected the number of individuals covered by schemes by artificially raising the costs of private medical scheme cover.

Under the community rating system, schemes need to attract new young members constantly to cross-subsidise the older members in the scheme. If this is not done, the average age in the pool will increase and the average premium will have to rise commensurately. The solvency ratios of schemes that are growing are placed under pressure because if a scheme's membership increases rapidly, its contribution income must rise steeply.

As noted previously, a scheme's solvency ratio is determined from the reserves as a percentage of the contributions. If the contributions increase without a similar increase in the reserves, the solvency ratio will decrease. Solvency requirements are a barrier to entry for new medical schemes trying to enter the private medical schemes market. It is unreasonable to expect potential entrants to raise enough capital, not only to fund their daily activities, but also to meet the statutory solvency requirements. Considering South Africa's aging population and the barriers to entry in the market, the effect of introducing unrealistic statutory solvency requirements were entirely predictable – substantial consolidation of existing medical schemes. Since 2000, the number of schemes operating in the medical schemes market has dropped by over 40% from 144 in 2000, to 82 in 2016 – an average rate of decline of almost four medical schemes per year over the period.

Statutory solvency requirements introduce a considerable regulatory bias in favour of some medical schemes and against others. A scheme that has accumulated reserves that exceed the required minimum is in a better position to attract new members than one that has a shortfall. It will be particularly difficult for new medical schemes to enter the market and rapidly growing schemes will be at a disadvantage relative to slowly growing ones. This is not a desirable situation given the substantial expected future demand for health care in the country.

The MSA also introduced open enrolment which is the practice whereby medical schemes are compelled to accept all individuals, regardless of age, sex or health status (subject only to their income and number of dependents or both). To reduce the probability of selecting high-risk individuals, schemes were permitted to apply waiting periods and penalties to those members over a certain age joining a scheme for the first time. But this was a mere band-aid to the regulatory problem created by community rating. Finally, the MSA made it compulsory for every scheme to provide PMBs which at an average cost of R680 per beneficiary per month in 2016, excludes a large proportion of the South African population.

The so-called act of 'social solidarity' contained in the MSA has had the effect of driving lower-income and healthy people out of the market or preventing them from even entering the market. The consequence is that the risk pool of insured people has become progressively smaller and less healthy, driving up contribution levels and making medical scheme cover unaffordable.

In contrast, when schemes are permitted to "risk rate" individual's health coverage, providers typically vary premiums based on factors associated with differences in expected health care costs, such as age, gender, health status, occupation, and geographic location. In cases where the individual is paying the full premium for coverage, health coverage providers will charge a higher premium to people who are older to recognise the higher expected costs. People seeking health insurance therefore pay premiums commensurate with their expected health risks.

With risk rating, the responsibility for an individual's health is placed directly in their own hands, whereas the theory of social solidarity, in practice, is neither efficient nor effective. If premiums are not varied to account for the differences in expected costs, the pool may attract a disproportionate share of older people with higher expected costs, raising the average cost and making coverage in the pool less attractive to younger and healthier people. This practise of selecting high-risk individuals is commonly referred to as adverse selection.

For obvious reasons, people who know that they are in poor health are more likely to seek health insurance than people in good health. A pool subject to significant adverse selection will continue to lose its healthier risks, causing its average costs to rise continually until the scheme becomes unviable and everyone in the scheme loses out – a process commonly referred to as the 'death spiral'.

To the extent that medical schemes are compelled to move away from economic and actuarial realities, they will be creating a situation that will be unsustainable. People, to the greatest degree possible, should be allowed to make their own decisions about their own lives and not be required to bear the costs of errors made by others. Government should not lock people into a preconceived notion of what is currently regarded as ideal. Changes will occur over time and, as the population ages, premiums will be forced to rise.

Regulatory add-ons have made healthcare much more expensive and complex than any other form of insurance. Social solidarity has caused the price of medical scheme cover and, more recently, gap cover to rise dramatically. Instead of heaping on more regulation, the obvious answer to increase the affordability and number of people covered by private medical financing arrangements would be to deregulate the market by making health "insurance" like other types of insurance.

The Cost Impact of Medical Scheme Legislation

The graph below is drawn from a study undertaken by Innovative Medicine SA (Brief 9 of 2010). It shows that there are almost 1.8 million taxpayers earning above the tax threshold who do not belong to a medical scheme.

These members are fully entitled to belong to a medical scheme and have the financial means to do so, especially the higher income bands. Considering that this graph is measuring tax payers (i.e. adults of working age), who would be supporting other dependents (minors and/or spouses), the potential membership that arguably should be in the medical scheme net, but are not, is around 4 million beneficiaries.

The current medical scheme membership is approximately 8.9 million beneficiaries, so the potential membership that are not participating, represent approximately 45% of the current medical scheme membership base.

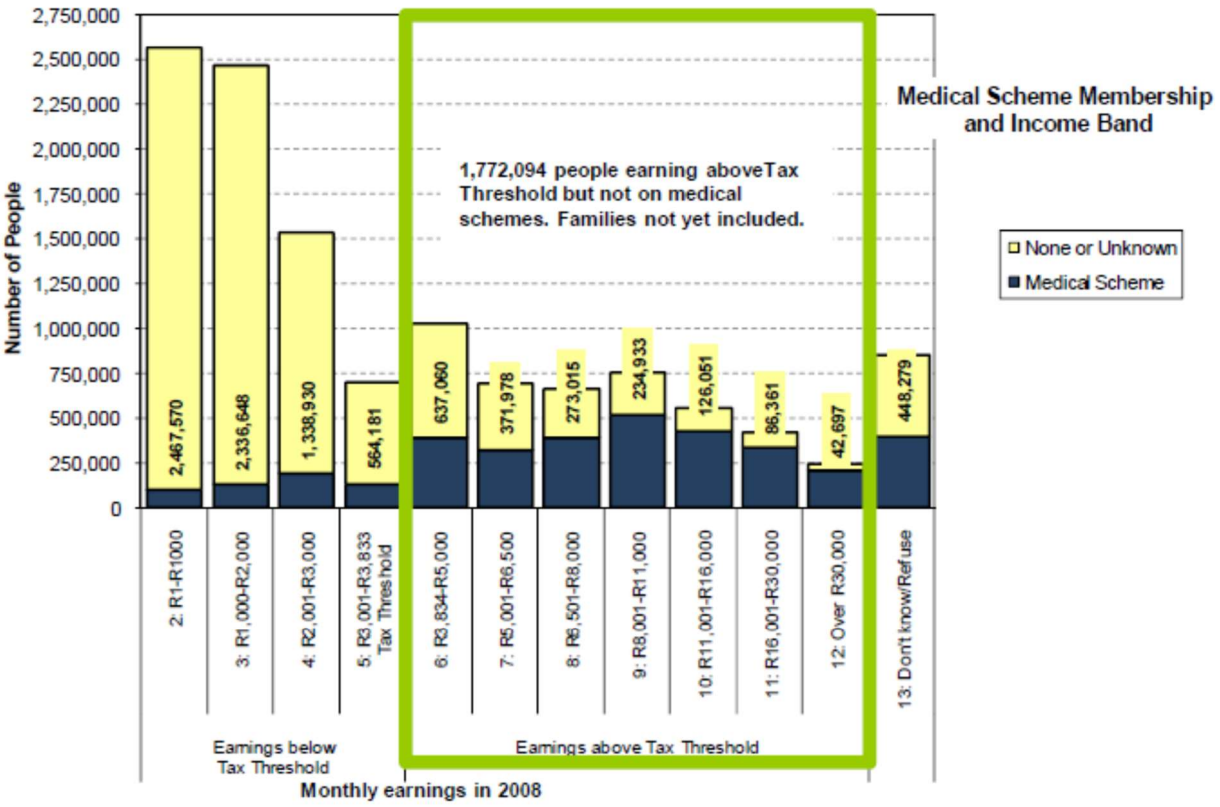
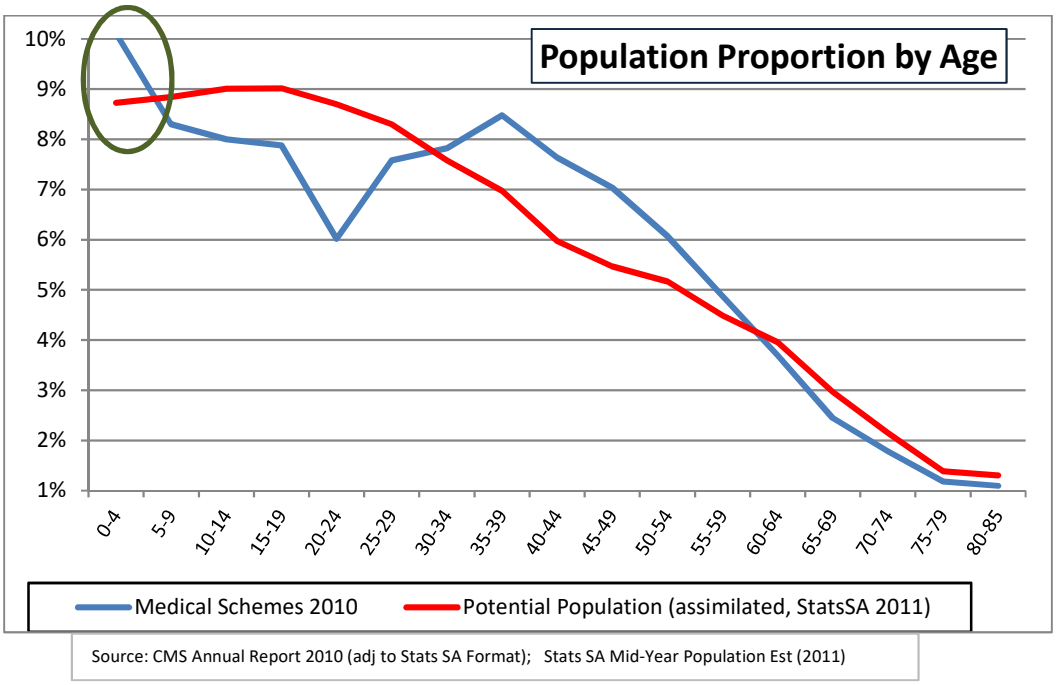


Figure 6: Medical Scheme Coverage by Income Band
Source: using data from GHS2008 from StatsSA

It is correctly assumed that members who have the financial means to belong to a medical scheme, but elect not to, are younger and/or healthier than the existing medical scheme population.

The graph below corroborates this – it compares the ***potential population*** age distribution by age band with that of the ***existing medical scheme members***.



Source: CMS Annual Report 2010 (adj to Stats SA Format); Stats SA Mid-Year Population Est (2011)

It is evident from the above graph that the existing medical membership is underrepresented in the age categories below 35 years and conversely over represented in those above 35 years.

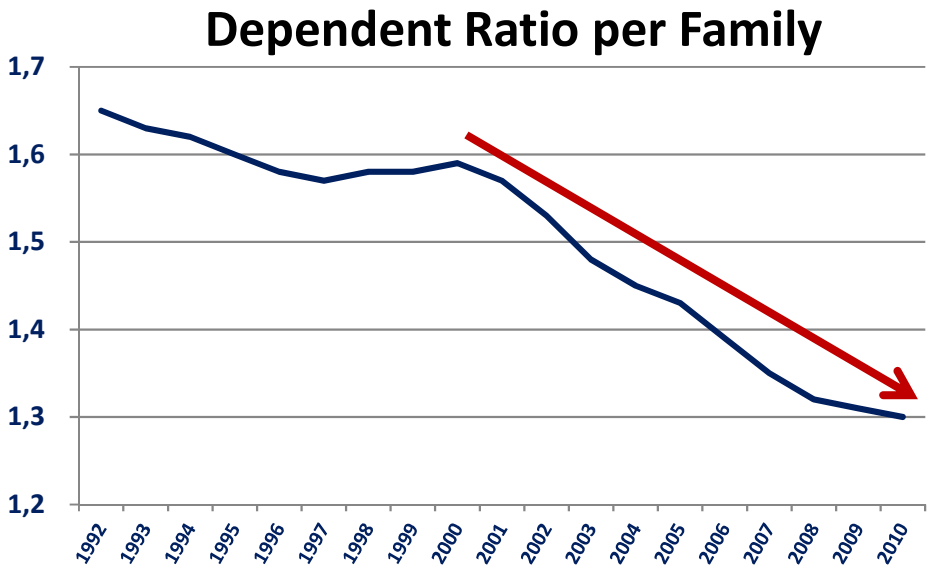
It is also well known that age is the ***most significant driver*** of health costs, especially in tertiary services such as specialist and hospital costs. Clearly, as costs accelerate with age, it becomes too risky to remain uninsured and therefore we witness the higher than normal representation in the 35+ year age groups of medical scheme beneficiaries.

The only exception is the high risk and cost often associated with childbirth – and hence again we witness an over representation of young infants in the medical scheme population[32] in the above graph (circled in green). Young couples intending to start a family join a medical scheme knowing that they will be entitled to full benefits for the confinements within 12 months. In any event, regardless of waiting periods, a child born to a medical scheme member is entitled to immediate benefits.

Families also become selective in terms of which family members they decide to add to their medical scheme cover. There is no legal prescription to have all dependents in a family on cover. Families can leave off their younger healthier children or choose only to cover the member with a serious health condition.

It is very apparent to see the substantial reduction in family size since introduction of the MSA in 2000.

[32] CMS data shows age categories of younger than 1 year and then from 1 to 4 years. However, StatsSA data only provides a category from 0 – 4 years so no direct comparison is possible for infants younger than 1 year.



This type of human behaviour represents classic examples of the opportunistic behaviour by consumers ('anti-selection'). Anti-selection has become widespread in the industry and is given legitimacy by the unfortunately skewed policy framework that underpins the MSA.

An actuarial study conducted by experienced healthcare actuary, Barry Childs (Lighthouse Actuarial, 2013), estimated that the impact of maintaining open enrolment and community rating without a concomitant balancing of these risks with mandatory participation, has raised claims costs in the private sector by 30 to 35%.

We submit that the regulatory framework that government has created for medical schemes to operate in for the past 18 years, is one of the main driving factors that has artificially raised the price of private healthcare in South Africa. Yet these high costs are now being used to justify the introduction of the governments NHI scheme. We submit that government cannot justify NHI on this basis of a fact (i.e. high costs) for which its own regulatory framework is largely responsible in causing.

The lack of appropriate regulation of the private sector has also been raised in the findings of the Competition Commission's Health Market Inquiry.[33] The appropriate action would be to rectify the regulatory framework for the private market – not eradicate the market altogether, as the NHI Bill clearly intends to do.

[33] Justice Sandile Ngcobo. Presentation of the HMI Provisional Report. Accessed 20-09-2018. Available at: http://www.compcom.co.za/wp-content/uploads/2018/07/Panel-Chair-Former-Chief-Justice-Sandile-Ngcobo.pdf

Alternative Solutions to the Proposed NHI Scheme

Most, if not all, developing countries face the challenge of having insufficient revenues to adequately provide for the healthcare needs and demands of their populations. Bowie and Adams from the Wharton Business School state, "In the majority of low and middle-income countries, the government cannot raise enough funds through general taxation to adequately finance the public health system and lack the institutional and organisational capacity to establish a functioning system of mandatory health insurance for the formally employed".[34]

Given South Africa's narrow tax base, high disease burden and limited resources, how should the government proceed with its healthcare reform? Alexander Preker, who was previously the lead economist at the World Bank, provides part of the solution. He states, "The ability and willingness of households in developing countries to pay for health care is far greater than the capacity of government to mobilise resources through taxation".[35] One would imagine that regular, small, fixed payments to a form of private health insurance would make intuitive sense – as opposed to the rare but devastatingly high out-of-pocket payments required when illness strikes.

Private health insurance increases access to quality care and improves consumer choice, leading to greater health system responsiveness. If given the option, the vast majority of South Africans would choose to go to a private health care facility. Indeed, a significant amount of out-of-pocket healthcare expenditure is already undertaken to access private health care and, as incomes improve, we can expect more people to join private medical scheme arrangements.

Expanding the private health insurance sector will provide consumers with greater choice and satisfaction. However, the biggest obstacles preventing medical schemes from rolling out options for low-income individuals are the regulations put in place by government. To the extent that medical schemes are compelled to move away from economic and actuarial realities, government will be creating a situation that is unsustainable. People, to the greatest degree possible, should be allowed to make their own decisions about their own lives and not be required to bear the costs of errors made by others. More specifically, government should not lock people into a preconceived notion of what it currently regards as ideal.

If government views "health care for all" to be politically essential, it could require the population to privately and individually purchase mandatory cover from privately competing insurers and medical schemes to insure against catastrophic, health-related events, but otherwise leave people to provide for their own and their families' medical-related and other needs. Moreover, instead of the government undertaking the management of taxpayer-provided funds, intended for covering the medical costs of the poor itself, it should put the task out to tender. In the same way as people have many options to choose from in household insurance, car insurance and myriad other products and services, publicly-funded patients will then have a multiplicity of medical schemes and insurers to choose from. Competition between public hospitals and clinics, and with private facilities, to win business from taxpayer-funded public health insurance beneficiaries, will thrive and ensure that the best service for the best price is given.

[34] Bowie, R and Adams, G (2005) Financial and Management Practice in a Voluntary Medical Insurance Company in the Developed World, background paper for Conference on Private Health Insurance in Developing Countries, Wharton Business School.
[35] Preker, A (2004) Voluntary Health Insurance in Development: Review of role in African region and other selected developing country experiences, World Bank.

Government should concentrate its efforts and scarce taxpayer resources on those who cannot afford health care. For these individuals, government could act as financier and let people decide for themselves where to spend their money – it is not necessary to finance the healthcare needs of the *entire* population. Doing so is not a particularly good use of scarce taxpayer resources. Spending in one area of the economy necessarily comes at the expense of other areas, so, if the government decides to dedicate more of the budget towards healthcare, it will mean less money available for such essential services as education, policing etc.

To fulfil the task of acting as financier for the poorest of the poor, government can and should enlist the support and help of the private sector by contracting out those services that can be provided more efficiently by private providers and administrators. Government's "laying the foundations for NHI" before the merits of the proposed system have been adequately discussed is putting the cart before the horse and comes at a cost for every person in South Africa, rich or poor.

Finally, the NHI Bill is thick on populist rhetoric and thin on critical details to make an informed decision on the health and economic impacts of the proposal. South Africa is facing an important tipping point that affects not only each one of us but also our children and grandchildren and generations to come. We can either choose systematic deregulation of the private sector on both the funding and provision sides, or we can choose even tighter controls where all our health care decisions are governed from the cradle to the grave. We need to have the courage to recognise the impending disaster and correct the mistakes before they are made.

If South Africans want better health outcomes, then we should be focussing on the institutions that we know result in higher levels of economic growth. The South African governments NHI is premised on a principle of compulsion – an anathema to personal and economic freedom. It is only with economic growth and increased incomes that South Africans will gain greater access to medicines and hospital services. Government, therefore, should focus on adopting policies that foster economic growth

Prepared by:

Jasson Urbach[36], Michael Settas[37] and Martin van Staden[38]

[36] Director, Free Market Foundation
[37] Health Policy Unit member, Free Market Foundation
[38] Legal Researcher, Free Market Foundation