SUBMISSION ON THE NATIONAL HEALTH INSURANCE BILL 2019

29 November 2019

Contents

Executive Summary

SECTION27 and the Treatment Action Campaign (TAC) welcome the opportunity to comment on the NHI Bill. We have developed a submission on the Bill that focuses on key changes to the Bill that will render it constitutionally compliant, are implementable, and will make it capable of achieving its aim of moving towards Universal Health Coverage.

1. Governance

The size and mandate of the NHI Fund, and the constitutional imperative of good governance, necessitates establishment of strong governance and improved accountability structures. Despite this clear need, the Bill centralises power in the Minister, who is involved in the appointment and removal of the Fund's board members, who are in turn accountable to the Minister. The Minister also plays significant role in the appointment of the Fund's Chief Executive Officer and of the various advisory committees of the Fund. The Bill makes no provision for any oversight structures.

The failure to put in place adequate checks and balances for the exercise of power inevitably places the NHI Fund and the health care system at risk. Our submission recommends specific amendments to the Bill that will improve the independence and resilience of the governance structure. These recommendations address issues including appointment and removal of board members, functions and powers of the Board, and advisory committees of the Board, and make provision for public participation in the governance of the Fund.

2. Principles put into practice

The rule of law, participation, transparency and universality are principles that must be put into practice under NHI.

Legislation must be accessible, clear, and predictable. Currently, the Bill establishes structures whose functions are not clear, and in some clauses, includes options for implementers, rather than providing certainty. We propose that the scope of the NHI Bill be reduced to include only provisions that are certain and can be implemented. Health systems change happens most

sustainably and effectively through experimentation and iteration. Not all aspects of the reforms need to be legislated in the Bill. Instead, we propose use of a process for testing interventions, and suggest that the Minister's extensive regulatory powers under section 55 will allow for decisions about mechanisms, options and structures to be made in the process of implementation.

Health care users and civil society must be able to participate in and have sight of the decisions and discussions under NHI. This includes participation in key committees, and the publication of all important information about contracting, benefits package development and decisions taken. A lack of participation and transparency has implications for accountability, buy-in and trust.

Finally, Universal Health Coverage requires universality. The exclusion of asylum seekers and undocumented migrants from care under NHI runs contrary to the principle of universality and is a significant and unlawful regression in access to health care services, which will be subject to legal challenge on constitutional grounds. Further, this regression is of public health concern, leaving these excluded populations without HIV care, maternal care, primary health care and most emergency medical treatment. We propose an NHI that lives up to the claim of pursuing Universal Health Coverage.

3. <u>Financing NHI</u>

Key to the delivery of equity, quality and universality in access to health care services under NHI will be the sustainable and affordable financing of NHI, and the efficient, equitable and effective expenditure of NHI funds. But this is not all. The dire state of the public health system will require additional investment. However, the financing plans and costing for NHI remain behind closed doors and instead, investment in health is decreasing through austerity budgeting in the medium term. We ask for clarity about the plans for financing the transition to NHI, including through shifts in conditional grants and the provincial equitable share, and through the removal of the medical scheme tax credit. Finally, we raise the contradictions within the Bill in relation to funding of emergency medical services.

4. The NHI cannot exist in a vacuum

While the NHI Bill makes reference to and proposes the amendment of some legislation, it fails to take advantage of legislation and processes that could be of use in achieving its aims. The Bill specifically provides for the non-application of the Competition Act 89 of 1998 to NHI. Such exclusion is not in the interests of health or of the NHI Fund and we propose the removal of the relevant section of the Bill. The Memorandum to the Bill also fails to acknowledge the recommendations of the Competition Commission Health Market Inquiry, implementation of which could be in the interests of the move towards NHI. We propose the consideration of the NHI Bill alongside the recommendations of the Competition Commission Health Market Inquiry.

5. What health care service users want from NHI

Finally, we have sought to inform people across South Africa about the NHI and to seek their inputs. We include consolidated inputs from 1280 people, gathered through community dialogues across seven provinces and from 232 people, gathered through an online and physical survey.

Introduction

1. This is a joint submission prepared by SECTION27 and the Treatment Action Campaign and endorsed by the South African Depression and Anxiety Group ("SADAG"), Lawyers for Human Rights ("LHR"), Sonke Gender Justice, the Organisation Undoing Tax Abuse ("OUTA"), Amnesty International, the Southern African Litigation Centre, the Public Service Accountability Monitor ("PSAM"), Cancer Association of South Africa ("CANSA"), Peoples' Health Movement ("PMH"); Dullah Omar Institute, South African Non-Communicable Diseases Alliance, and the National Mental Health Alliance Partnership.

2. SECTION27 is a public interest law centre that seeks to influence, develop and use the law to protect, promote and advance human rights. Our name is drawn from section 27 of the Constitution, which enshrines everyone's right to health care services, food, water and social security.

3. The Treatment Action Campaign ("TAC") is a membership-based organisation with over 8000 members in 193 branches across the country. It works in seven of the country's nine provinces. It is the premier HIV and health activist organisation in the country and works in the interests of its members who are the people who most need the public health system to work. TAC is working with the People Living with HIV ("PLHIV") sector on the Ritshidze Project, a project that monitors 400 sites in 27 districts across eight provinces. It covers sites with the highest HIV burden in the country, which are responsible for half of the PLHIV on treatment, to make invaluable input in relation to the retention crisis and the state of health care services.

4. SECTION27 and the TAC support wholeheartedly any legitimate efforts to achieve quality, universal health coverage. It is in this context that we make these submissions.

5. We are in agreement that the current two tiered health system is inequitable and that there is a need to change health funding. We are further in agreement that the right of everyone to access to health care services means that everyone should be able to access

quality services on the basis of need, rather than on the basis of ability to pay. This agreement is unequivocal. However, this agreement does not require agreement with the way in which the change to the health system and the establishment of the NHI Fund has been laid out in the NHI Bill. Disagreement with aspects of the NHI Bill does not, in our case, equate to anti-poor sentiment or satisfaction with the status quo. Instead, the purpose behind our criticism is that we are concerned to ensure the health system reforms that are required are in fact implementable and sustainable.

6. SECTION27 and TAC made a submission on the 2018 Draft NHI Bill in which we expressed two overarching concerns with the 2018 Bill. First, we submitted, the proposed changes under the 2018 Bill were likely further to weaken the health care system by creating undue complexity, and deepening governance and financial management problems. They did not establish a coherent health system structure and risked exacerbating current dysfunctionality. Second, the 2018 Bill did not take into account the parlous state of the health care system currently and therefore, even if the 2018 Bill were to set up a coherent structure, it lacked specificity on how it would overcome the serious defects in the health system and, thus, would not be capable of implementation. Both concerns meant, we suggested, that we ran the risk of not achieving the goal of NHI: universal health coverage.

7. There has been very little change to what we view as the worrying components of the Draft 2018 Bill in the 2019 Bill. The concerns that we raised in our 2018 submission are, therefore, still relevant and we encourage the consideration of that submission, which can be found here: http://section27.org.za/wp-content/uploads/2018/09/NHI-submission-from-SECTION27-and-TAC-21-September-2018.pdf.

8. The NHI Bill envisages the establishment of a complex and large fund that will be complicated to manage and tempting to loot from. Many contracts will be created that will require skilled HR capacity to manage – skills we do not presently have in the public service. New structures will be created with overlapping functions and unclear relations to each other, further complicating the political tensions already present in the health

system. Excess capacity will be leveraged from the private sector to serve all health service users, but how this will be done in practice remains opaque. And maybe most importantly, it is unclear what will be done to address the underlying political and governance challenges that are the sand in the gears of our public service.

9. Legally, section 27 of the Constitution requires that government takes reasonable measures progressively to realise the right of access to health care services. Reasonableness has been interpreted in this context to require that the measures must be comprehensive, coherent and coordinated[1] and must be reasonably conceived and implemented.[2]

10. We are of the view that considerable work is required to make the proposals of the NHI Bill coherent and reasonably conceived. Implementation of the NHI proposals also risks regression in access to health care services, a violation of section 27 of the Constitution.

11. Recognising the clear need for change to our health system does not require uncritical acceptance of the proposals in the NHI Bill. In fact, this recognition requires instead real engagement with the details of the Bill and proposal of alternatives, to help make it a success. As such, in this submission, we seek to ventilate some of our concerns and to make clear suggestions to render the NHI Bill constitutionally compliant and capable of achieving its goal: to move SA towards universal health coverage.

12. In addition to our specific recommendations, we urge that the NHI Bill should be considered together with the Medical Schemes Amendment Bill and the findings of the Competition Commission's Health Market Inquiry ("HMI"). The final report of the Health Market Inquiry contains valuable recommendations with direct relevance for NHI. In addition, the NHI Bill will impact medical schemes as well as the Medical Schemes Amendment Bill. A previous version of the Medical Schemes Amendment Bill was published for public comment, but it has not yet been submitted to parliament - the

[1] *Government of RSA and Others v Grootboom and Others* 2001 (1) SA 46, para 39 and 40.
[2] *Grootboom* para 40-43.

Department of Health should be asked to consider the Medical Schemes Amendment Bill in the light of the HMI report and recommendations and process the Amendment Bill accordingly. The most rational approach is to consider all these various sources of evidence and various reforms holistically.

13. We cover five key themes in this submission:

    13.1. Governance under NHI;
    13.2. Principles put into practice: the rule of law, participation, transparency and universality;
    13.3. Financing NHI;
    13.4. The NHI cannot exist in a vacuum: Competition Law and the Competition Commission's Health Market Inquiry; and
    13.5. What health service users have told us about what they want from NHI.

1. Governance under NHI

14. The introduction of NHI will transform the current intergovernmental fiscal arrangements, eventually vesting all health financing in the NHI Fund. The size and function of the NHI Fund, and the constitutional imperative of good governance,[3] necessitates establishment of strong governance and improved accountability structures.

15. Chapter 4 of the Bill sets out the governing structure of the Fund (in the form of a board that is accountable to the Minister), as well as the powers and functions of the Board.

16. As currently presented, there is a centralisation of power with the Minister and little separation between the Fund and the Minister. The Minister is empowered to:

[3] The Constitution recognises the importance of good governance: Section 195 deals with basic values and principles governing public administration. These principles apply to organs of state (the proposed NHI Fund falls within the definition of an organ of state) and compels them to adhere to principles of good governance.

16.1. appoint the ad hoc advisory panel which interviews shortlisted candidates for the Board;[4]

16.2. appoint the candidates recommended by the advisory panel;[5]

16.3. appoint the chairperson of the Board;[6]

16.4. remove board members;[7] and

16.5. dissolve the Board.[8]

17. The Minister is also responsible for the appointment and removal of the Fund's Chief Executive Officer (CEO) based on the recommendations of the Board.[9] Over and above this, after consultation with the Board, the Minister also appoints members of the Benefits Advisory, Health Care Benefits Pricing and the Stakeholder Advisory Committee.

18. One of the significant contributors to the current failures in the public health system is the blurring of lines between political and administrative leadership.[10] The question of adequate independence was dealt with in *Glenister II* where the court held that:

> "adequate independence does not require insulation from political accountability. In the modern polis, that would be impossible. And it would be averse to our uniquely South African constitutional structure. What is required is not insulation from political accountability, but only insulation from a degree of management by political actors that threatens imminently to stifle the independent functioning and operations of the unit."[11]

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[4] Section 13(3)(a).
[5] Sections 13(3)(b) read with section 13(4).
[6] Section 14(1).
[7] Section 13(8).
[8] Section 13(9).
[9] Section 19(2).
[10] Research on Governance in State Owned Enterprises by the Dullah Omar Institute warns against lack of transparency and centralisation of powers to the executive as this opens up room for political interference. The Institute proposes that in order for there to be accountability and transparency, there needs to be a degree of separation between the executive and the administration. See also Dasandi, N., & Esteve, M. (2017) The politics–bureaucracy interface in developing countries *Public Administration and Development*, *37*(4) 231-245; and Balabanova, D., Mills, A., Conteh, L., Akkazieva, B., Banteyerga, H., Dash, U., & Kidanu, A. (2013) Good Health at Low Cost 25 years on: lessons for the future of health systems strengthening *The Lancet*, *381*(9883), 2118-2133.
[11] *Glenister v President of the Republic of South Africa and Others* [2011] ZACC 6; 2011 (3) SA 347 (CC); 2011 (7) BCLR 651(CC) (*Glenister II*) at para 216.

19. The centralisation of power in the Minister in relation to the NHI Fund and its governance and management constitutes a real threat to the independence of the Fund and its functioning. In light of this, we set out below some recommendations for amendment of the wording of the Bill to improve the resilience of the governance structure and protect it from undue political interference.

Independence

20. Section 12 of the Bill does not specifically provide for the independence of the Board, as stipulated in previous versions of the Bill. The independence of a board is critical for ensuring that the board can objectively fulfil its functions openly, with integrity and without fear or favour. It also enables the board to perform its oversight function. The establishment of an independent board will also instil public confidence in the Fund. We therefore recommend the insertion of the word independent in section 12 so that it reads—

> "An independent Board that is accountable to the Minister is hereby established to govern the Fund in accordance with the provision of the Public Finance Management Act."

21. Of course, the insertion of legislative language that stipulates that the Board must be independent does not, on its own, achieve the result. Independence must be built into the appointments to and functioning of the Board.

Appointment of board members

22. In terms of section 13(2) and section 13(3) of the Bill, following the public nomination process for board member candidates, an *ad hoc* advisory panel, appointed by the Minister, must conduct public interviews of the shortlisted candidates and forward its recommendations to the Minister for approval. It is not clear who is responsible for preparing the shortlist of candidates and the Bill is silent on the criteria for selecting members of the *ad hoc* advisory body.

23. It is important that the appointment of board members and executives is done in a transparent manner that instils public confidence. For example, to inspire confidence in the new SARS commissioner, one of the recommendations made in the Report of the Commission on Inquiry into Tax Administration and Governance by SARS was that members selected for the interviewing panel "should be apolitical and not answerable to any constituency and should be persons of high standing who are able to inspire confidence across the tax-paying spectrum."[12] The Report also recommends that there should be criteria against which to evaluate the attributes of the members of the [interviewing] panel.[13] We therefore recommend that the *ad hoc* advisory panel must be composed of at least the following:

    i. Representation from the National Treasury – ideally an administrative head;
    ii. Director General of the National Department of Health;
    iii. Three members of the Portfolio Committee on Health (National Assembly), designated by that Committee, and representing three different political parties;
    iv. Persons with experience in governance and healthcare financing.

    Provision for the composition of the *ad hoc* advisory panel should be included within section 13(3).

24. The Bill should set out the principles upon which appointment to the Board is based. For this, we recommend drawing from section 4(1)(b) of the Media and Development and Diversity Agency Act[14] which sets out that appointment of board members must be based on the principles of transparency and openness, public participation in the nomination process and publication of shortlisted candidates. We further propose that the published

[12] The Report of the Commission on Inquiry into Tax Administration and Governance by SARS 11 December 2018 http://www.inqcomm.co.za/Docs/media/SARS%20Commission%20Final%20Report.pdf Accessed 7 November 2019.
[13] Id at page 187.
[14] Media Development and Diversity Act 14 of 2002. The Media Development and Diversity is a Schedule 3 PFMA entity.

list of shortlisted candidates should contain the names of both the nominees and the nominators, similar to the requirements of the Road Accident Fund Act.[15] There must also be mechanisms in place to allow the public to make submissions regarding a recommended candidate, and all these submissions must be considered when selecting candidates for shortlisting. Once the board members have been appointed, the recommendations of the selection panel should be made public.[16]

We propose amendment of section 13(2) as follows:

> 13(2) "Whenever it is necessary to appoint a member referred to in subsection 13(1) to the Board, subject to subsection 13(8)(2), the Minister shall –
>
> (a) issue in the Gazette and national news media a call for the public nomination of candidates who comply with the criteria in subsection 13(5), to serve on the Board;
>
> (b) publish a list of nominees received in response to such invitation, which list shall include the names of the nominators; and
>
> (c) publish the process by which members of the public may make submissions on nominees, which submissions will be considered by the ad hoc advisory panel.

25. The composition of a governing structure is a key factor for the performance of an entity. In addition to its independence, it is imperative that the Fund's Board has the right balance of knowledge, skills, and experience.[17] It is also important that the appointment criteria is clear in specifying honesty, integrity and expertise as key considerations for appointment to the Board. The composition of the Board must also broadly reflect diversity across various attributes including age, race, gender and disability. We therefore

[15] Section 10(9)(b) of the Road Accident Fund Act 56 of 1996. The Road Accident Fund is a Schedule 3 PFMA entity.

[16] See recommendation made by The Report of the Commission on Inquiry into Tax Administration and Governance by SARS 11 December 2018, http://www.inqcomm.co.za/Docs/media/SARS%20Commission%20Final%20Report.pdf in relation to the appointment of the SARS Commissioner, page 188.

[17] The board must reflect a balance of expertise, and must include both people who are in practice and those in academia.

propose that these additional criteria are laid out in section 13(5), and that the section be amended as follows:

(5) A Board member is appointed for a term not exceeding five years, which is renewable only once, and must—

(a) be a fit and proper person;

(b) have appropriate technical expertise, skills and knowledge or experience <u>in practice or in academia</u> in health care service financing, health economics, public health planning, monitoring and evaluation, law, actuarial sciences, information technology <u>or</u> communication;

(c) <u>be a person of honesty and integrity;</u>

(d) be able to perform effectively and in the interests of the general public;

(e) not be employed by the State; and

(f) not have any personal or professional interest in the Fund or the health sector that would interfere with the performance in good faith of his or her duties as a Board member.

(5A) <u>The composition of the Board must broadly reflect the diversity of the country, including in relation to age, race, gender and disability.</u>

Removal from the Board and dissolution of the Board

26. Section 13(8) of the Bill states that the Minister may remove a board member who is disqualified in terms of any law[18] or who is unable to continue to perform their functions of office *for any other reason*.[19] In terms of section 13(9), the Minister may dissolve the Board *on good cause*. Removal for "any other reason" and dissolving the Board "on good cause" is entirely at the discretion of the Minister and can thus be susceptible to political whims.[20] This undermines the independence of the Board. The threat of removal without

[18] Section 13(8)(a) of the Bill.
[19] Section 13(8)(c) of the Bill.
[20] *Dawood v Minister of Home Affairs; Shalabi v Minister of Home Affairs; Thomas v Minister of Home Affairs* [2000] ZACC 8; 2000 (3) SA 936 (CC); 2000 (8) BCLR 837 (CC) at paras 54-5. See also *SOS Support Public Broadcasting Coalition and Others v South African Broadcasting Corporation SOC Limited and Others; SOS Support Public Broadcasting Coalition and Others v South African Broadcasting Corporation SOC Limited and*

any oversight, on any ground, and without due inquiry, would render board members unlikely to express views which may not align with that of the government or the majority of board members.

27. We therefore recommend that a provision should be included to the effect that the removal of a board member in terms of section 13(8) should be done only after due inquiry and upon recommendation by the Board.

28. The Bill is also silent on the procedure to be followed when replacing a member who has either resigned or has been removed from the Board. Finally, there is no explicit requirement for board members to formally declare conflicts of interest. We propose the amendment of section 13(8) as follows:

    13(8)(1) " The Minister may, after due inquiry, and upon recommendation by the Board, remove a board member on account of any or all of the following:

    (i) misconduct;

    (ii) inability to perform the duties of his or her office efficiently;

    (iii) absence from three consecutive meetings of the Board without the permission of the Chairperson, except on good cause shown;

    (iv) failure to disclose an interest contemplated by section 16 or voting or attendance at, or participation in, proceedings of the Board while having an interest contemplated in section 16(2)(b); and

    (v) his or her becoming disqualified in terms of section 13(10).

    13(8)(2) "Whenever a position on the Board becomes vacant before the expiry of the term of office referred to in subsection 13(5), the Minister may appoint any other competent person, who meets the criteria listed in section 13(5) of the Act, to serve for the unexpired portion of the term of office of the previous member irrespective of when the vacancy occurs.

Others [2017] ZAGPJHC 289 on the unfettered discretion exercised in relation to executive appointments at the SABC.

29. The Bill should also be amended to insert a provision dealing with disqualification from appointment on the Board. We propose the insertion of a section 13(10) reading:

> "A person may not be appointed as a Board member if he or she –
>
> a. is not ordinarily resident in South Africa;
> b. is an unrehabilitated insolvent;
> c. has been removed from an office of trust on account of misconduct; or
> d. has at any time been convicted (whether in the Republic or elsewhere) of theft, fraud, forgery or perjury.

30. The dissolution of a board is a drastic measure and the consequence is that an interim board is appointed to act for a maximum period of three months. In our view, a drastic measure such as this should not be unilateral but should be appropriately scrutinised and accompanied by parliamentary oversight. The dissolution of the Board should require an inquiry and must be based on specified, objective grounds. Objective grounds for the dissolution of the Board may include poor or non-performance of functions and abuse of power. Under such circumstances, the Minister should be obligated to refer the matter to the National Assembly for consideration and where the National Assembly recommends that the Board be dissolved, the Minister has no discretion and must dissolve the Board. We also recommend that the National Assembly must play an oversight role in the appointment of the Acting Board. As such, we propose the amendment of section 13(9) so that it reads as follows:

> 13(9)(a) "The Minister must, after due inquiry and the adoption of a resolution by the National Assembly, dissolve the Board on account of any of the following:
>
> i. failure to discharge its fiduciary duties;
> ii. poor or non-performance of its duties as contemplated; or
> iii. abuse of power.

Functions and powers of the Board

31. In addition to its role as the accounting authority of the Fund, section 15(3) of the Bill states that the Board must advise the Minister on a variety of matters. While some of the

matters on which the Board must advise the Minister relate to matters about which the Minister must make a final decision (the services to be funded,[21] the pricing of services,[22] and the transition from the current health system to "full implementation" of the NHI Fund[23]), others are purely operational matters (the management and administration of the Fund,[24] terms and conditions of Fund employees,[25] and collective bargaining[26]).

32. Providing for this advisory role implies that the Minister is empowered to make decisions in relation to the issues on which the Board advises him/her. The operational matters on which the Board advises the Minister lie within the CEO's jurisdiction. Only the CEO is empowered to make operational decisions about the Fund, and thus it is the CEO who would benefit from such advice. We suggest, therefore, that the operational and governance advisory functions of the Board be separated and that the Board advises the CEO on operational and the Minister on governance matters.

Advisory committees of the Fund

33. As noted above, there are three committees that are established as committees "of the Fund".[27] The committees are, however, appointed by the Minister, "after" rather "in" consultation with the Board,[28] and each has a representative of the Minister on the committee, and has its chairperson appointed by the Minister.[29]

34. A number of concerns about the Benefits Advisory Committee and the Health Care Benefits Pricing Committee arise. Section 25(3)(b) provides that a member of the Benefits Advisory Committee will cease to be a member when they are no longer a member of the institution that nominated them. There is no reason for this provision if the Benefits

[21] Section 15(3)(b).
[22] Section 15(3)(c).
[23] Section 15(3)(i).
[24] Section 15(3)(a).
[25] Section 15(3)(e).
[26] Section 15(3)(f).
[27] The Benefits Advisory Committee under section 25(1) and the Health Care Benefits Pricing Committee under section 26(1).
[28] See sections 25(1) and 26(1).
[29] Sections 25(6) and section 26(4).

Advisory Committee is not, as appears to be the case, intended to be a representative committee. We propose that this section be removed.

35. Very little detail is provided about the Health Care Benefits Pricing Committee. This is surprising given the importance of this committee to the functioning of the Fund and of NHI in general. We propose that the process for the appointment of members of this committee and their terms of office should be the same as is laid out for the Benefits Advisory Committee. The role of the Health Care Benefits Pricing Committee should also be laid out in more detail.

36. The concentration of powers in the Minister in relation to the Benefits Advisory Committee and the Health Care Benefits Pricing Committee should be reconsidered. We propose that sections 25 and 26 be amended to provide for appointment of advisory committees by the Minister in consultation with the Board and for the chairpersons of each committee to be appointed by the committee itself.

37. Finally, there appears to be no link between the Benefits Advisory Committee and the Health Care Benefits Pricing Committee, bringing into question how rational rationing of health care services under NHI will work. Advice to the Fund and the Minister in relation to benefits and the price to be paid for those benefits should be aligned.

2. Principles put into practice

The rule of law: health system revolution through legislation

38. The NHI Bill seeks to re-engineer the health system through what Schneider, Lehmann and Gilson[30] call "legislative, financial and compliance levers". In so doing it "ignore[s] the abundant global evidence that health systems function as complex adaptive systems" and are unlikely to "be controlled, let alone reoriented into completely new and better performance by strings pulled at the top, however necessary or well designed."

[30] https://www.spotlightnsp.co.za/2018/09/21/building-public-health-system-capacity-for-nhi-learning-from-disease-specific-successes-for-system-development/.

39. Legislation is, by its nature, a top-down enterprise. It is for this reason that section 59(1)(a) of the Constitution requires public participation in legislation making. But even ideal public participation in law making does not allow for the kind of iterative reform agenda that is needed for fundamental health systems change.

40. While legislation, early on in the process, is needed for some components of NHI (such as the establishment of the Fund), this is not the case for all aspects of NHI. Legislating on matters that are unclear (including reference to possible options for payment of health care services),[31] and establishing structures that will require testing and possibly change or abandonment (such as Contracting Units for Primary Care ("CUPs")) is problematic for a number of reasons.

    40.1. First, legislating is an exercise in precision. One of the formative principles of the rule of law is that law, and legislation, must be accessible, intelligible, clear and predictable.[32] An Act is not merely a policy statement but is binding and must be capable of being understood and followed.

    40.2. Second, while promulgating the various sections of an Act at different times allows for the phasing in of change, this kind of phasing does not meet the need for experimentation and learning which is the hallmark of lasting health systems change.[33] While dramatic change is needed, the process of securing it should be through evolution and iteration.

41. We propose that the scope of the NHI Bill be reduced to include only provisions that are certain and can be implemented. The Minister's extensive regulatory powers under section 55 will allow for decisions about mechanisms, options and structures to be made in the process of implementation, following experimentation.

[31] Such as the reference to fund transfers "based on a global budget or Diagnosis Related Groups" (emphasis added) in section 35(2).
[32] See T Bingham *The Rule of Law* (2010) Penguin Books.
[33] See, for example, Balabanova, D., Mills, A., Conteh, L., Akkazieva, B., Banteyerga, H., Dash, U., & Kidanu, A. (2013) Good Health at Low Cost 25 years on: lessons for the future of health systems strengthening *The Lancet*, *381*(9883), 2118-2133.

42. Where a decision has not yet been taken (such as whether hospitals will be paid based on global budgets or Diagnostic Related Groups; or the type of taxes to be used to fund NHI), the options under consideration need not be provided in the legislation. Doing so makes the law less, rather than more, certain and may open the Bill up to legal challenge.

43. Similarly, where, as in the case of CUPs, much more work needs to be done to determine whether a structure is needed, what it should do, how it will operate, and how it will relate to other structures, there is no need to establish the structure in the Bill. Indeed, the Bill provides, in its amendments to the National Health Act 61 of 2003, and section 37 of the Bill that the roles of DHMOs and CUPs overlap to a significant extent,[34] and that DHMOs will be responsible for establishing CUPs[35] and performing their functions until they are able to perform their own legislated functions.[36] This makes clear that the structures themselves need not be legislated at this stage for their proposed functions to be filled. It seems more appropriate to begin the process of active purchasing of health care services without legislating the local structures that may eventually play some role in this purchasing. In this way, options can be tested, processes refined, and models developed without the need for legislative amendments.

44. We propose that rather than introducing, through legislation, structures that need to be developed, capacitated, tested, and possibly changed, we legislate a process for thoughtful experimentation and piloting and provide specifically for capacitation and stewardship. This allows for considered and lasting health systems change without adding layers of complexity and administration, at great cost, before knowing whether they are needed and how they will work.

45. In particular we propose the following:

[34] Including in relation to their obligation to manage and facilitate the provision of services.
[35] Section 31B(1) of the amendments to the National Health Act.
[36] Section 31B(6) of the amendments to the National Health Act.

45.1. The amendment of section 35(2) to read "The Fund must transfer funds directly to accredited and contracted central, provincial, regional, specialised and district hospitals".

45.2. The deletion of section 35(3), section 37, section 41(3)(a), and the amendment of the National Health Act that seeks to include section 31B.

45.3. The deletion of the details of different types of taxes in section 49(2)(a) which, it appears from the Memorandum to the Bill, are options but will not necessarily all be used as sources of funding for the Fund.

45.4. The inclusion of a requirement for the Fund to budget for and establish processes to support experimentation and learning at the front line of service delivery, in collaboration with relevant actors.

Participation: the inclusion of civil society and health service users in all decisions and processes

46. The participation of the users of health care services in decisions and processes that determine their access to health care services is recognised as a key pillar of universal health coverage.[37] It is not a matter of representivity. Instead, it is a recognition that even technical decisions are not value-neutral, and of the importance of creating policy, implementation plans and execution that are responsive to the needs of people. Section 195 of the Constitution makes responsiveness and people-centredness an obligation of public administration. This goes beyond public participation processes in law-making and extends into involvement in governance structures and decision-making bodies.

47. The UN Political Declaration on Universal Health Coverage, 2019, to which South Africa is a signatory, recognises "that people's engagement, particularly of women and girls, families and communities, and the inclusion of all relevant stakeholders is one of the core components of health system governance, to fully empower all people in improving and protecting their own health..." States further commit to "engage all relevant stakeholders… to provide input to the development, implementation and evaluation of

[37] D Rajan et al "Institutionalising participatory health governance: lessons from nine years of the National Health Assembly model in Thailand" *BMJ Global Health* 10 August 2019.

health- and social-related policies and reviewing progress for the achievement of national objectives for universal health coverage."

48. The NHI Bill envisages very limited involvement of civil society and health care service users in the discussions of and decisions on NHI.

49. Provision is made for representatives of civil society and users in the Stakeholders Advisory Committee but not in the other two committees of the NHI Fund – the Benefits Advisory Committee and the Health Care Benefits Pricing Committee.

50. The Stakeholders Advisory Committee, the only place for civil society and health service users, has no clear function and is not designated as an advisory committee of the Fund, in spite of its name. Real and meaningful participation of civil society and health service users is not, therefore, provided for, contrary to accepted practice around universal health coverage.

51. The Stakeholder Advisory Committee should be seen as key for facilitating public participation in the decision making of the Fund. If properly constituted and empowered, it will contribute invaluable evidence and expertise needed for the implementation of the NHI (including such evidence collected through the Ritshidze Project, described at the beginning of this submission, for example). The Stakeholder Advisory Committee would be in a position to advise the Benefits Advisory Committee on issues relating to availability and suitability of health care services; and the Health Care Benefits Pricing Committee on the affordability of health care services. An example of a similar structure successfully performing an important participatory governance role can be found in the National Health Assembly in Thailand.

52. To remedy the shortcomings identified above, we propose the following:

    52.1. Amendment of section 25(2) and section 26(2) to include that the composition of the Benefits Advisory Committee and the Health Care Benefits Pricing

Committee should include two members of the Stakeholder Advisory Committee that represent health service users and civil society.

52.2. Amendment of section 27 so that it reads as follows:

> "The Minister must, after consultation with the Board and by notice in the Gazette, appoint a Stakeholder Advisory Committee as one of the advisory committees of the Fund. The committee shall comprise of representatives from the statutory health professions councils, health public entities; organised labour, civil society organisations, associations of health professionals and providers, as well as patient advocacy groups in such a manner as may be prescribed."

52.3. Amendment of section 15(3) to insert a provision on the advisory role of the Stakeholder Advisory Committee to read as follows:

> 15(3) The Board must advise the Chief Executive Officer on any matter concerning—
> (j) the best practices to safeguard the rights of users, improve access to health care services and complaints management through the Stakeholder Advisory Committee.

53. In addition to the involvement of civil society and health service users in the committees of the Fund, consideration should be given to their involvement in other structures established under NHI. There is, at present, no National Health Act-required consultative structure at district level (which exists, albeit barely functions, at national and provincial levels). While the amendment to the National Health Act that establishes District Health Management Offices provides for the interaction between District Health Management Offices and community representatives through District Health Councils, there is no clear requirement for such community representatives to be appointed to District Health Councils under section 31(2) of the Act. There is merely a new obligation for District Health

Councils to “promote community participation in the planning, provision and evaluation of health care services” in the new section 31(3)(bA).

54. Meaningful participation of health care users and civil society at all levels of the health system is, at present, sorely absent. The establishment of District Health Management Offices provides an opportunity to change this, to ensure the responsiveness of health care services to the service users in the area.

55. We propose the further amendment of section 31(2)(a)(iv) of the National Health Act to require that the five additional persons appointed to the District Health Council are health service users in the district and are appointed to represent such health service users. We further propose the development of a programme to capacitate District Health Councils to perform their functions effectively as provided for in the Act.

Transparency

56. Despite various provisions in the Public Finance Management Act 1 of 1999 and the Protection of Access to Information Act 2 of 2000 (PAIA), information relating to the public healthcare system often remains hidden from the public. This includes information on procurement, epidemiological information, and information on service delivery. Sometimes routine information is only released after a PAIA request has been submitted. In some instances, PAIA requests have been ignored – and while there are legal steps that can be taken in such cases, these come with legal costs which few can afford, as well as significant delay. A lack of transparency is an even greater problem in the private sector.

57. To increase public trust in NHI and to reduce the risk of corruption under NHI, it is imperative that all NHI-related processes and decisions are as transparent as possible. In our view, this requires specific provisions in law to guarantee such transparency.

58. The NHI Act should unambiguously state that certain types of information should be made available to the public as a matter of routine and without the public having to submit requests for information in terms of PAIA. Such a provision would protect NHI from the

current situation whereby PAIA is at times misused as an excuse to delay or deny access to information.

59. Types of information that the public should have routine access to include:

59.1 Details of all transactions of the NHI Fund.

59.2 Details of all decisions relating to the benefit package under NHI.

59.3 Minutes of all meetings of the advisory committees of the Fund and details of their decisions.

59.4 Details of all health technology assessments (HTA) and justifications for HTA decisions.

59.5 In relation to the Office of Health Products Procurement, the routine publication of:

59.5.1 Requests for information, bid specifications, requests for quotations and requests for proposals;

59.5.2 Bid evaluation committee meeting minutes and bid adjudication meeting minutes;

59.5.3 Letters to the accounting officer / accounting authority recommending a preferred bidder to be appointed;

59.5.4 Award letters to preferred bidders;

59.5.5 Final contract of sale, service level agreement, or other form of agreement recording the legal obligations of parties to perform and pay;

59.5.6 All signed addenda making changes to original terms and conditions

59.5.7 Minutes of meetings in which changes to agreement terms were negotiated and/or agreed;

59.5.8 Decisions to white or blacklist specific suppliers.

59.6 Details of all decisions by the NHI Fund or its agents to contract or not to contract certain facilities or groups of facilities.

60. There may be legitimate debate regarding how general or how specific law should be regarding an issue such as transparency. We have taken this in mind in the proposals we make below. Rather than listing every key piece of information that should be public, we have identified a series of key instances where small changes to the current wording of the Bill can in meaningful ways increase the transparency of the NHI system that will be created by the Bill.

61. In line with the above considerations, and with due consideration for the fact that law should not be overly specific, we propose the following changes to the Bill:

61.1 The insertion of the word "transparent" in the preamble as follows:

> "create a single <u>transparent</u> framework throughout the Republic for the public funding and public purchasing of health care services, medicines, health goods and health related products, and to eliminate the fragmentation of health care funding in the Republic;"

61.2 The amendment of section 6(c) to read as follows:

> "6(c) to have routine access to any information or records relating to his or her health kept by the Fund, as provided for in the Promotion of Access to Information Act, but without having to make a request in terms of the Promotion of Access to Information Act or having to provide any justification for accessing the information;"

61.3 The insertion of the words "most transparent" into section 10(2) of the Bill as follows:

"10(2) The Fund must perform its functions in the most cost-effective, most transparent and most efficient manner possible and in accordance with the values and principles mentioned in section 195 of the Constitution and the provisions of the Public Finance Management Act."

61.4 The addition of the following provision as provision (p) in section 11(1) of the Bill:

"11(1)(p) Routinely make as much information as possible available to the public regarding decisions and processes of the Fund and its committees, including, but not limited to, information on benefits and the price of benefits, procurement and contracting decisions, health technology assessments, epidemiological and demographic information, information pertaining to quality measurement, and information relating to fraud investigations."

61.5 The insertion of the words "in as transparent a manner as possible" in section 38(3) of the Bill as follows:

"38(3) The Office of Health Products Procurement must in as transparent a manner as possible"

61.6 The insertion in section 39(6) of the Bill of the words "such evaluations must routinely be made available to the public" as follows:

"39(6) The performance of an accredited health care service provider or health establishment must be monitored and evaluated in accordance with this Act, such evaluations must routinely be made available to the public, and appropriate sanctions must be applied where there is deviation from contractual obligations as per the law."

61.7 The addition of sub-section 7 to section 40 of the Bill as follows (drawing on the existing section 40(1)):

"40(7) Information must routinely be shared with the public regarding assessment of population health needs, financing, purchasing, patient registration numbers and characteristics, service provider contracting and reimbursement, utilisation patterns, performance management, parameters for the procurement of health goods, and fraud and risk management."

Universality: Population coverage

62. Currently, everyone is entitled to free primary health care services, and free termination of pregnancy and all pregnant and lactating women and children under the age of six years are entitled to free health care services.[38] Everyone is entitled to HIV care.[39] No one may be refused emergency medical treatment.[40] Refugees, asylum seekers and undocumented migrants from SADC states needing hospital services are entitled to be treated the same as South Africans, including being means tested to determine the level of state subsidisation of the cost of their health care services.[41]

63. The NHI Bill provides in section 4 that permanent residents and refugees will be treated in the same way as South Africans but that asylum seekers and undocumented migrants will only be entitled to emergency medical services and services for notifiable conditions of public health concern. It further provides that all children (explicitly including children of asylum seekers and undocumented migrants) will be entitled to "basic health care services". Emergency medical services is defined in the Bill as "services provided by any private or public entity dedicated, staffed and equipped to offer pre-hospital acute medical treatment and transport of the ill or injured". It therefore appears to exclude any emergency medical treatment at hospital. "Basic health care services" as they relate to children has never been defined.

[38] National Health Act, section 4(3).
[39] National Department of Health Directive, 2008.
[40] Constitution, section 27(3) and National Health Act, section 5.
[41] Uniform Patient Fee Schedule, Annexure H.

64. The result of the NHI Bill provisions is a significant and unlawful[42] regression in access to health care services by asylum seekers, undocumented migrants and their children, which will be subject to legal challenge on constitutional grounds.

65. The regression in access to services for these groups is also of public health concern. Not included in the services available to asylum seekers and undocumented migrants would be screening and treatment for HIV. South Africa has the highest HIV prevalence in the world. The pandemic affects everyone living in South Africa regardless of legal status but migrant populations are heavily burdened by HIV.[43] South Africa has pledged to "leave no one behind" in its work to achieve the 90-90-90 targets. Excluding asylum seekers and undocumented people from HIV care would constitute a major and fatal set back in the pursuit of this goal, affecting both South Africans and migrants alike. It is also likely to increase mother to child transmission of HIV, undoing the advances South Africa has made in this regard.

66. Asylum seekers and undocumented migrants under NHI would also be excluded from sexual and reproductive health care services, specifically provided to accord to everyone in terms of section 27 of the Constitution, and recognised as a key component of universal health coverage.[44] A lack of access to contraceptive services and safe abortion, for example, would put already vulnerable women, and their families and children, at ever greater risk. The exclusion of maternal health care services from the package of services available to asylum seekers and undocumented migrants under NHI would see South Africa reversing its gains in relation to maternal mortality.

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[42] *Certification of the Constitution of the Republic of South Africa*, 1996 (CCT 23/96) [1996] ZACC 26; 1996 (4) SA 744 (CC); *Government of the Republic of South Africa and Others v Grootboom and Others* [2000] ZACC 19; 2001 (1) SA 46, para 34; *Minister of Health and Others v Treatment Action Campaign and Others* (No 2) (CCT8/02) [2002] ZACC 15; 2002 (5) SA 721 at para 46; *Mazibuko and Others v City of Johannesburg and Others* [2009] ZACC 28; CCT 39/09, [2009] ZACC 28; 2010 (3) BCLR 239 (CC) at para 47; *Head of Department : Mpumalanga Department of Education and Another v Hoërskool Ermelo and* Another [2009] ZACC 32; 2010 (2) SA 415 (CC); *Jaftha v Schoeman and Others; Van Rooyen v Stoltz and Others* [2004] ZACC 25; 2005 (2) SA 140 (CC); 2005 (1) BCLR 78 (CC) at paras 31-4.

[43] Joint United Nations Programme on HIV/AIDS (UNAIDS) (2014) *The Gap Report: Migrants*, available at: https://www.unaids.org/sites/default/files/media_asset/04_Migrants.pdf.

[44] https://www.who.int/pmnch/media/news/2018/sexual-reproductive-health-rights/en/

67. The exclusion of emergency medical treatment beyond pre-hospital care not only violates section 27(3) of the Constitution as it applies to asylum seekers and undocumented migrants, but will place the patients themselves in real danger and the staff of ambulance services in the invidious position of having to leave people in need of care at the roadside once the limit of what can be provided in transit has been reached.

68. The limitation of services available to children to an undefined package of "basic health care services" constitutes a further regression in realisation of the right of access to health care services for children and a violation of the constitutional provision that "a child's best interests are of paramount importance in every matter concerning the child."[45]

69. Differential treatment of refugees and asylum seekers in the Bill is itself problematic. An asylum seeker is a person who has submitted an application for refugee status, has received an asylum seekers permit, and awaits a final decision on their refugee status application. In the eyes of the state, an asylum seeker is as likely as not to be seeking refuge and unable to return to their country due to persecution. There is, therefore, no justification for treating asylum seekers and refugees differently.

70. Section 4(1) of the NHI Bill includes sub-section (e) which provides for the purchasing of services by the Fund for "certain categories or individual foreigners determined by the Minister of Home Affairs, after consultation with the Minister and the Minister of Finance, by notice in the Gazette". Due to the vagueness of this sub-section in the light of the fairly exhaustive listing of categories of people in section 4 as a whole, we do not know who would be likely to be included under this provision. No guidance is provided in the Memorandum to the Bill.

71. Our proposal in relation to population coverage is that section 4 of the NHI Bill be amended as follows:

    71.1. Section 4(1) be amended to include a sub-section (f), (g) and (h) as follows:

[45] Constitution, section 28(3).

(f) asylum seekers

(g) undocumented migrants from SADC states

(h) all children, regardless of their citizenship or immigration status

71.2. Section 4(2) be amended as follows:

(2) An undocumented migrant who is not from a SADC state is entitled to-

(a) primary health care services;

(b) emergency medical treatment;

(c) services for notifiable conditions of public health concern;

(d) sexual and reproductive health care services; and

(e) services related to HIV.

71.3. Section 4(4) be deleted.

3. Financing NHI

72. Key to the delivery of equity, quality and universality in access to health care services under NHI will be the sustainable and affordable financing of NHI, and the efficient, equitable and effective expenditure of NHI funds. This will require significant change from the current situation in which the distribution of financial, human and administrative resources is highly inequitable. The NHI White Paper found that "the benefit incidence of health care in South Africa is very 'pro-rich' with the richest 20% of the population receiving 36% of total benefits (despite having a 'health need share' of less than 10%) while the poorest 20% receive only 12.5% of the benefits (despite having a 'health need share' of more than 25%)."[46] This gross inequality plays out in unequal life expectancy, burdens of disease and quality of life between those with and without the means to access expensive private health services.

[46] NHI White Paper at 17.

73. The public health sector is chronically short of staff, equipment and adequate infrastructure, while the private health sector has good access to medical professionals, equipment and modern, functional infrastructure. Provincial departments of health scrape by each financial year, using clever budgeting techniques to cross-subsidise shortfalls for immediate operational requirements at the expense of suppliers and maintaining infrastructure. At the same time, hospital groups, private health care providers and medical schemes make profits that allow them to reward shareholders and invest in new capacity.

74. At the same time, the final Health Market Inquiry ("HMI") Report found that private health care "is characterised by high and rising costs … and significant overutilization without stakeholders having been able to demonstrate associated improvements in health outcomes"[47]. It found "highly concentrated funders and facilities markets, disempowered and uninformed consumers, a general absence of value-based purchasing, practitioners who are subject to little regulation and failures of accountability at all levels."[48] The Council for Medical Schemes indicates that corruption and fraud in the private health sector amounts to about R22 billion annually.[49]

75. Wastage and inefficiency are highly prevalent in the public sector too, which incurs billions of Rand in irregular expenditure annually and where corruption, particularly in procurement, is also rife.[50]

76. It is also true that the public health sector massively subsidises the private through the training and development of medical professionals and research expenditure, among others.

77. Based on National Treasury figures, in the 2019/2020 financial year, total national spending on health care was about R490 billion, or 9% of GDP (which is comparable to the

[47] Competition Commission's Report on the Health Market Inquiry at 1.
[48] Competition Commission's Report on the Health Market Inquiry at 2.
[49] Statement by the Presidency "Justice sector closes in on health sector corruption, 02 October 2019. Available at: www.thepresidency.gov.za/press-statements/justice-system-closes-health-sector-corruption.
[50] Ibid.

proportion of GDP spent on the National Health Service in the United Kingdom). This is the total of R222 billion of consolidated spending on public health, R11 billion of donor funding and R250 billion of private sector spend. The latter includes R207 billion in medical scheme contributions, R35 billion of out-of-pocket expenses, R5 billion in contributions for health insurance products such as gap cover, and R2.6 billion spent by employers providing health services to their workers.[51]

78. It seems that it is not a lack of resources, but their inequitable distribution, historical underinvestment in the public sector, corruption, wastage and mismanagement that is in the way of access to quality health care services for all.

79. Regarding the way that financing of NHI, and by direct relation, the financing of public and private health care reform – are dealt with in the Bill and the Memorandum, we have concerns and questions in the following areas:

    79.1. The lack of transparency and public involvement in the costing of NHI and in developing appropriate financing plans;
    79.2. The continued underfunding of public health in the budget, not just to plug shortfalls but to undertake the necessary quality improvements in the medium term that are necessary for the NHI transition;
    79.3. The transfer of conditional grant funding, including the HIV/AIDS grant, to the NHI Fund;
    79.4. The transfer of equitable share funding to the NHI Fund;
    79.5. The phasing out of medical scheme tax credits; and
    79.6. The lack of clarity relating to funding for Emergency Medical Services.

Costing the NHI and development of appropriate financing plans

80. We welcome that Section 2.4 of the Memorandum recognises that a carefully phased approach to financing and reforms aims to ensure that "health care should be seen as a

[51] Kahn "The fatal flaws of NHI" *Business Day* 15 August 2019. Available at: www.businesslive.co.za/fm/features/2019-08-15-the-fatal-flaws-of-nhi.

social investment and not be subject to trading as a commodity". We agree with this principle and concur that a poorly planned transition to NHI would indeed risk a situation in which private actors in health care can exploit gaps and inadequacies. For health care to become a public good and a social investment, the health care system must operate efficiently and effectively at all times.

81. Unfortunately, many of the details about NHI funding remain unclear. Clarity and transparency in relation to the funding of NHI is desperately needed, both to confirm the policy choices being made and to allay public fears. It is insufficient to claim that additional funding for NHI will not be sought until the economy improves. Detailed plans for each stage of the transition and how each stage is to be funded should be provided, in the Memorandum to the Bill, in the Treasury discussion document that was never made public, and, at the appropriate time, in a Money Bill. Consideration of the NHI Bill without any clear indication of funding makes it very difficult for parliament to see whether they are passing a Bill that is mere aspiration, or one that has been planned for and can be funded, albeit in stages.

82. We are not suggesting that all information about financing must or can be known at this stage. But the complete absence of any apparent costing or budgeting or plan for raising funds disables public debate and is of real concern.

Austerity budgeting is harming public health and delaying NHI

83. The reality is that the move towards NHI is not supported in the budget. The Minister himself has recognised that in real terms, budget allocations for health have declined over the past decade.[52] CPI of about 5.0% and population growth of about 1.5% means that to break even with average inflation and demand, health funding must grow by at least 6.5% per year. However, demand for health care services and medical price inflation is higher than CPI, as evidenced in the large increases to medical scheme tariffs each year (in 2020 Discovery is proposing an almost 10% average increase). Moreover, as widely

[52] "South Africa is facing a doctor shortage – here's why" *Business Tech* 20 October 2019. Available at: https://businesstech.co.za/news/government/346538/south-africa-is-a-facing-a-doctor-shortage-heres-why/.

documented, personnel costs (i.e. wages and benefits) continue to outstrip CPI inflation in government, including in health departments.

84. All this means that the average growth of consolidated health spending proposed in the 2019 Medium Term Budget Policy Statement (MTBPS) of 7.0% for the medium term (until 2022/23) will be insufficient to maintain, let alone transform levels of staffing, equipment and infrastructure, and hence improve quality, in the public health system. In the 2019 MTBPS the Treasury states that "given the macroeconomic and fiscal outlook, the estimates to roll out NHI that were published in the NHI Green Paper in 2011 and White Paper in 2017 are no longer affordable."[53]

85. The faulty logic of cutting back social expenditure to prioritise debt repayments, known as austerity, especially during difficult economic times, is now widely recognised by the IMF, the World Bank and has been so in mainstream scholarship for some time.[54] In periods of stagnation or recession, government can stimulate the economy through targeted spending, interest rate cuts and other methods to spur a recovery. By doing the opposite, the downturn is reinforced and those who need protection from insecurity see their services and protections cut away at the very moment they are needed most.

86. We recommend that, as provided for in the Memorandum, investing in health care is recognised as an investment in productivity and economic growth, as well as in equity and human rights, and that this recognition is acted upon. Implementation and appropriate financing of an improved National Quality Improvement Plan (see our 2018 submission), the Health Market Inquiry recommendations and the NHI are exactly the kind of reform projects that could drive the socio-economic transformation that is necessary for higher, sustained and more inclusive economic growth.

[53] National Treasury, Medium Term Budget Policy Statement, 2019, at 37.
[54] Sibeko, B. (2019). The cost of austerity: Lessons for South Africa. Institute for Economic Justice Working Paper Series, No 2. Engler, P. & Klein,M. 2017. "Austerity Measures Amplified Crisis in Spain, Portugal, and Italy," DIW Economic Bulletin, DIW Berlin, German Institute for Economic Research, vol. 7(8), pages 89-93. https://ideas.repec.org/a/diw/diwdeb/2017-8-1.html; OHCR. 2017. Report on austerity measures and economic and social rights. Available at: www.ohchr.org/Documents/Issues/Development/RightsCrisis/E-2013-82_en.pdf.

87. There are multiple options[55] available to government to raise additional resources from wealth, income from wealth, high incomes and the corporate and financial sectors. Rather than a simple focus on cutting expenditure to repay debt, measures must be taken to:

87.1. Capacitate SARS to combat illicit financial flows, tax base erosion and illegal profit shifting, estimated annually at 4% of GDP by the Mbeki Panel;[56]

87.2. Ensure wealthier South Africans pay their fair share, including through tax reform. Statistics South Africa's recent report[57] reminds us that SA remains the most unequal country in the world;

87.3. Gradually increase the level of corporate income tax, which has been reduced from 50% in 1990s to only 28% today;

87.4. Prosecuting those involved in the corruption and looting of state resources that is estimated at more than R27 billion annually, and costing approximately 76 000 jobs;[58]

87.5. Improving the financial capacity and accountability of government departments and entities that contribute to the R61 billion of irregular expenditure found by the Auditor General in 2018/19;[59]

87.6. Turning around failing SOEs like Eskom, SAA, SABC and Denel, which are costing tens of billions of Rand in bailouts annually.

88. Despite these options, the budget allocations for implementing the National Quality Improvement Plan (NQIP) are far too little. The MTBPS states that R75 million will be allocated for this in 2020/21, R125 million in 2021/22 and R175 million in 2022/23. Given the scale of the challenges, it is far from clear if this amount will be sufficient to ensure that more facilities are ready for accreditation by the NHI Fund by 2022/23.

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[55] Submission to the Select and Standing Committees on Finance, "Budgeting in an era of austerity" *Budget Justice Coalition*, 26 February 2019 at 26. Available at: https://budgetjusticesa.org/assets/downloads/Budget-Justice-Coalition-5-year-Review-Submission-to-Finance-Committees.pdf.

[56] State of Tax and Wage Evasion: A South African Guide 2019" *Alternative Information and Development Centre*, 2019. Available at: http://aidc.org.za/download/Illicit-capital-flows/Tax-Evasion-and-South-Africa.pdf.

[57] "Inequality Trends in South Africa: a multidimensional analysis" *Statistics South Africa*, October 2019. Available at: http://www.statssa.gov.za/?page_id=1854&PPN=Report-03-10-19&SCH=7680.

[58] "Corruption costs SA GDP at least R27 billion annually, and 76 000 jobs" *BusinessTech*, 01 September 2017.

[59] Presentation by the Auditor General to the Standing Committee on Public Accounts, 23 October 2019. Available at: https://pmg.org.za/files/191023_PFMA_-_AG_Roadshow.PPTX.

89. Section 8.1(c) of the Memorandum states that National Treasury has commissioned an intervention-based costing tool which provides estimates of "15 or so" interventions related to NHI. These include removing user fees, extending CCMDD, extending the rollout of ARVs, increasing antenatal visits, rolling out capitation model for GPs, cataract surgery programme, and establishing the Fund. The Treasury estimates in the 2019 MTBPS that the full roll out of these interventions would require an additional R33 billion annually from 2025/26, and foresees no additional allocations in Budget 2020 and the Medium-Term Expenditure Framework to pay for this.

90. Such budgeting constitutes an effective block on the road to NHI.

91. Clearly, many of the proposals contained in the NHI Bill, such as the 300+ CUPs and the 52 DHMOs, will require additional funding to be implemented. Yet Section 8.4 of the Memorandum suggests that the NHI Grant baseline will not be increased in the medium-term. <u>The only foreseeable outcome of this budgeting is that many of the proposals in the NHI Bill will simply not be implemented.</u>

92. At the same time, the National Department of Health continues to underspend on the NHI conditional grant, to the tune of R600 million in 2018/19[60] and R240 million so far in the first 6 months of the current 2019/20 financial year.[61] This underspending is simply not justifiable when budget constraints in provincial health departments are so severe. At 8.2 in the Memorandum, a recommendation is made that unspent funds (which relate mainly to goods and services)[62] are reprioritised for the filling of statutory posts at provincial level such as interns and community service officers.

93. This austerity budgeting – recognising the budget shortfalls at provincial level and using NHI funds to paper over some of the cracks – is not conducive to the long-term

[60] National Treasury, 2019 Budget Review. Available at: www.treasury.gov.za.
[61] National Treasury, 2019 Adjusted Estimates of National Expenditure, Vote 16 Health, October 2019. Available at www.treasury.gov.za.
[62] Ibid.

development of NHI. It clearly illustrates that the health budget overall is not sufficient to maintain or improve the public health system and fund the new commitments originating from the transition to NHI.

Shifting conditional grants to the NHI Fund

94. Section 49 of the Bill states that Health Conditional Grants will be transferred to the NHI Fund from 2021/22, amounting to about R50 billion. The Bill explicitly includes the Comprehensive HIV/AIDS and TB Grant as one that will be moved by this date.

95. No explanation is provided in the Bill or the Memorandum as to how this transfer will take place, or what implications it will have for the organisation and implementation of the HIV/AIDS programme, which more than 4 million people depend upon for life-sustaining anti-retroviral therapy.

96. Since it will, for a period, be the major source of funding for the nascent NHI Fund, we would like to know if the funding for this critical programme is at risk. We wish to see the implementation plan for this change as soon as possible so that we can work with the Department of Health and the Fund to ensure as seamless a switch as possible. It must be noted that a significant portion of total HIV/AIDS spending is provided by the donor community, who would also need to be brought on board for any major shift in the funding or implementation of the HIV/AIDS grant to take place.

Shifting provinces' equitable share allocation to the NHI Fund

97. Section 49(2)(a)(i) of the Bill envisages that from 2022/23, the equitable share allocation to provinces to provide health care services will be transferred to the NHI Fund, in part or in full.

98. Once money is consolidated in the Fund, which will have the power to invest surpluses and save money for emergencies or economic downturns, subject to good governance and management, and political will, that pot of money should only grow year after year. This would be preferable to the current situation, where provincial government's decide

how much of their equitable share allocation to spend on health each budget cycle. This has resulted in some provinces, including the North West, reducing the share of their budget that goes to health in recent years.

99. We are reassured by Section 3(4) of the Bill which recognises that the Bill won't effect changes to the funding and functions of national and provincial departments until legislation contemplated in Sections 77, 214 and 227 of the Constitution has been affected. However, we recommend that function shifts are dealt with extremely carefully and planned and undertaken with the support of provinces and health care users so that both services and intergovernmental relations are not disrupted.

100. We also note that the equitable share formula will need to be reviewed in light of the proposed changes and call for public participation in the process of formulating and designing such changes.

Medical scheme tax credits

101. We note that, instead of subsidising private health care, the funding amounting to approximately R4 billion annually previously allocated to medical scheme tax subsidies will be redirected to the NHI Fund by 2021/22.

102. These tax credits have to-date assisted lower-income earners to access medical aid plans and there is a legitimate concern that the removal of the tax credit, though it has also subsidised middle and higher income earners, will result in lower income earners no longer being able to afford their plans. This may result in the downgrade or termination of medical aid subscriptions by lower income earners, who will thus be added to the already oversubscribed public health system. This will only add to the burden of care in the public sector and without additional funding to compensate, which is not envisaged in the 2019 MTBPS or the Memorandum to the Bill, will put further pressure on public services.

103. We recommend that consideration be given by the National Treasury to tax and spending measures that may be undertaken in Budget 2020 and Budget 2021 to alleviate the impact of the withdrawal of medical scheme tax credits on low-income earners that may be pushed out of private medical insurance as a result.

104. We also recommend that the Department of Health work with the Council for Medical Schemes to design and implement measures aimed at retaining lower income earners in the medical scheme system in the medium-term, in line with the recommendations of the Health Market Inquiry. Improvements to incentives and benefits will likely not be enough to achieve this. Consideration will have to be given to lowering the fees paid by lower income earners and increasing the progressivity of scheme tiers and tariffs.

Emergency Medical Services

105. The NHI Bill stipulates that the NHI Fund will purchase services from both public and private ambulance providers. The detail of exactly how this will work is still worryingly unclear.

106. Both public and private emergency medical services will be paid, according to section 35(4)(a) of the Bill on a "capped case-based fee basis with adjustments made for case severity, where necessary" and private ambulance services will be contracted individually by the NHI Fund but provinces, as "management agents", will provide public ambulance services.[63]

107. Confusingly, the Bill also provides that public ambulance services will "be reimbursed through the provincial equitable share".[64] How provinces can legally be instructed to pay for public ambulances on a capped case-based fee basis with adjustments for case severity when paying from the provincial equitable share, is unclear.

[63] Section 32(2)(a).
[64] Section 35(4)(b).

108. A further complexity arises in the distinction between emergency medical services and ambulance services in the proposed addition of section 31A to the National Health Act. Section 31A(3)(k) provides that one of the functions of the District Health Management Office is to "facilitate the integration of public and private health care services such as emergency medical services but excluding public ambulance services". What this means, in the light of the definition of emergency medical services as "pre-hospital acute medical treatment and transport of the ill or injured", is unclear.

109. We suggest that further consideration be given to the provision of and payment for emergency medical services under NHI. NHI provides a good opportunity to substantially improve the quality of emergency medical service many people receive. This will however require that government strategizes more ambitiously and puts in place appropriate funding mechanisms, contract management and implementation structures. In particular, it requires care in managing the wider contracting of private ambulance services to avoid the problems seen in the Free State, Limpopo, Mpumalanga and the North West in which contracting of private ambulance services has led to alleged overcharging and sub-standard quality of service from the contracted private providers.[65]

[65] See reporting by Spotlight here: https://www.spotlightnsp.co.za/2019/03/06/health4sale-limpopo-air-ambulance-service-grounded-after-dodgy-contract/; https://www.spotlightnsp.co.za/2018/10/17/health4sale-government-employee-represents-private-company-as-free-state-again-prepares-to-outsource-part-of-ambulance-service/; https://www.spotlightnsp.co.za/2018/05/18/health4sale-how-the-limpopo-department-of-health-went-rogue-to-protect-buthelezi-hems/; https://www.spotlightnsp.co.za/2018/04/25/health4sale-part-6-magashule-cleared-way-controversial-private-ambulance-company-cash/; https://www.spotlightnsp.co.za/2018/04/24/health4sale-part-5-controversial-private-ambulance-company-line-new-free-state-tender/; https://www.spotlightnsp.co.za/2018/04/23/health4sale-part-4-buthelezi-ems-running-taxi-service-not-ambulance-service-doctors-nurses/; https://www.spotlightnsp.co.za/2018/04/20/mpumalanga-department-health-broke-rules-controversial-ambulance-company/; https://www.spotlightnsp.co.za/2018/04/19/northwest-pays-double-dubious-private-ambulance-service/; https://www.spotlightnsp.co.za/2018/04/18/health4sale-north-west-blows-hiv-money-controversial-private-ambulance-service/

4. The NHI cannot exist in a vacuum

Competition Law and the NHI

110. The NHI Bill states in section 3(5):

> *The Competition Act, 1998 (Act No. 89 of 1998), is not applicable to any transactions concluded in terms of this Act.*

111. This clause is potentially problematic for the efficient functioning of the healthcare system. While the NHI Fund may require particular transactions to be exempt from the Competition Act (for example, to enable forms of collective bargaining), it would be an over-reach to exclude all transactions from the Competition Act and may have a detrimental effect on the Fund and on access to health care services.

112. The purpose of the Competition Act is to promote and maintain competition in the country in order to attain several goals, including promoting efficiency in the economy, providing consumers with competitive prices, promoting employment and social welfare of South Africans, and ensuring small and medium enterprises ("SMEs") and historically disadvantaged people and businesses ("HDI") have opportunities for participation in markets. These are important national goals.

113. The transactions referred to in the NHI Bill may involve various practices that are prohibited by the Competition Act, including, for example:

- *Restrictive horizontal practices* which are agreements between firms or associations of firms that substantially prevent or lessen competition or involve particular listed practices, particularly collusion including directly or indirectly fixing purchase prices, selling prices and trading conditions, dividing markets or allocating customers, or collusive tendering.
- *Restrictive vertical practices* that substantially lessen or prevent competition, for example, exclusive contracting or rebate structures which may exclude

competitors from the market, maintaining high levels of concentration, as well as minimum resale price maintenance.

- *Abuse of a dominant position* which includes a range of practices, for example, charging excessive prices, refusing to give a competitor access to an essential facility and exclusionary acts. Exclusionary acts include the following: requiring or inducing a supplier or customer not to deal with a competitor, refusing to supply scarce goods or services, selling goods or services on condition that the buyer purchases separate goods or services unrelated to the object of the contract, selling goods or services at predatory prices, buying up a scarce supply of intermediate goods or resources required by a competitor, and engaging in a margin squeeze.

114. Furthermore, in terms of the Competition Amendment Act, it is prohibited for a dominant firm in a *designated sector* (sectors have not been designated thus far):

- to directly or indirectly, require from or impose on a supplier that is a small and medium business or a firm controlled or owned by historically disadvantaged persons, unfair prices or other trading conditions.
- to avoid purchasing, or refuse to purchase, goods or services from a supplier that is a small and medium business, or a firm controlled or owned by historically disadvantaged persons in order to circumvent this.

115. As such, the Competition Act predominantly has strong protections for companies against exclusionary and anti-competitive behaviour with particular safeguards for SME and HDI businesses.

The role for Competition Law in relation to the NHI Fund

116. There is a strong role for Competition Law to operate in a complementary manner to the NHI Bill to maximise benefits to the Fund, the industry and to individual health service users. The Health Market Inquiry Report found that there are a range of inefficiencies in the private health sector, some of which will require regulations and other interventions

to address. Making the Competition Act inapplicable to transactions concluded in terms of the NHI Bill may have several unintended consequences:

Collusion

117. Absent the application of the Competition Act, there may be an enhanced scope for collusion. Companies that are colluding in tendering for the Fund could argue that they are not subject to the Act as their conduct relates to a "transaction under the Act". This is of concern as collusion in medication and medical products is prevalent locally and internationally.

118. Firstly, there have historically been cases of explicit collusion in the medical sector in South Africa:

- In 2008, Tiger Brands and Adcock Ingram Critical Care agreed to administrative penalties in terms of collusive behaviour in the supply of intravenous medical products supplied to private and public hospitals through collusive tendering, and market allocation.[66]
- In 2010, a consent order was reached in relation to a tender for HIV test kits in which fines were levied on Hosannah Medical and Shekinah Medical.[67]

119. Secondly, there have been several cases of collusion that increased the price of medicines internationally, including several in the last year:

- In August 2019, The UK Competition and Market Authority (CMA) entered into an agreement in which Aspen would pay GBP 8 million in damages to the CMA for collusion (including market sharing) that raised the prices of medicines sold to the NHS.[68]

[66] Competition Commission of South Africa, Press statement: Adcock Ingram Critical Care admits involvement in cartel and agrees to penalty representing 8% of turnover, 8 May 2008

[67] http://www.compcom.co.za/wp-content/uploads/2014/09/Annual-Conference-Paper-Combatting-Bid-Rigging.pdf; ; Competition Commission v Shekinah Medical & Disposables & Hosannah Medical & Disposables available from http://www.saflii.org/za/cases/ZACT/2013/44.html

[68] Competition and Market Authority UK, "Press release: CMA pharma probe secures £8m for the NHS", 14 August 2019, https://www.gov.uk/government/news/cma-pharma-probe-secures-8m-for-the-nhs

- The US Department of Justice has charged pharmaceutical companies for price fixing, bid rigging and customer allocation that increased the prices of generic medication.[69]

120. Collusion in the supply of medical and pharmaceutical equipment is particularly concerning as there are several structural features of these markets which make them susceptible to collusion. This includes high levels of concentration and multi-market contact. As such, by excluding transactions engaged in by the Fund from screening and scrutiny by the competition authorities who have specialist knowledge and expertise in investigating and prosecuting collusion it is likely that the current Bill creates a gap in which potential collusion can go unchecked.

Provisions relating to dominance

121. It is possible that as the dominant purchaser of healthcare services, the Fund would be subject to the dominance provisions of the Act. This includes, for example, the prevention of predatory pricing and ensuring that the Fund as a dominant buyer does impose fair prices or trading conditions on SME or HDI businesses (if healthcare is designated). While this may constrain the Fund to some extent, these provisions exist to support business and competition and to maintain a healthy competitive environment, particularly for SME and HDI providers. The provisions therefore play an important counterweight to price in ensuring sustainability and diversity in supply. They prevent a scenario in which a focus entirely on costs leads to the exit of smaller and local industry competitors, leading to complete dependence on one or two large suppliers who then operate from a position of bargaining strength. As such, it is unclear as to why adherence with these provisions would be problematic for the Fund.

122. Furthermore, abuse of dominance in the sector has been assessed in other supply chains in the past. For example, in 2003 the Competition Commission reached settlements with Boehringer Ingelheim and GlaxoSmithKline in relation to antiretrovirals pricing for abuse of their dominant positions, leading to the companies agreeing to issue voluntary

[69] The United States Department of Justice, "Press release: Pharmaceutical Company admits to price fixing in violation of antitrust law, resolves related False Claims Act Violations." 31 May 2019, https://www.justice.gov/opa/pr/pharmaceutical-company-admits-price-fixing-violation-antitrust-law-resolves-related-false

licences to generic manufacturers. This led to a reduction in prices for ARVs. As such, there are likely other circumstances in which the Competition Act may directly lead to a more efficient and better outcome for patients.

The role of exemptions

123. The Competition Act allows for exemption applications to be made. One potential concern historically has been that collective bargaining by practitioners and medical schemes was found to be anti-competitive. The South African Medical Association (SAMA) and the Hospital Association of South Africa (HASA) were subject to consent orders and administrative penalties in 2003/4 which subsequently left a regulatory vacuum for price determination, and has been argued to have led to increased prices in the private sector. There may be a concern that were the Competition Act to apply, a similar situation may result.

124. However, if this is a concern and collective bargaining by practitioners is seen as a more efficient means of negotiating, it would be better for the Fund to simply apply for an exemption for that particular type of transaction rather than simply removing the application of Competition Law to the sector as a whole. It can be noted that on a forward-looking basis, transactions negotiated under the NHI Fund can be structured with input from the Competition Authorities in a manner that is procompetitive or falls more distinctly within a clear regulatory framework. For example, the Competition Commission Healthcare Market Inquiry has recommended that a Supply Side Regulator determine such tariffs in a Multilateral Negotiating Forum that can be used as a mechanism for such negotiations. As such, there are various mechanisms that can be used by the Fund, which would work comfortably in parallel with the Competition Act and in cooperation with the Competition Authorities.

Conclusion

125. Given the important role that competition in markets can play in reducing the ability of firms to abuse their dominance, it is essential that the Competition Authorities continue to play a role in monitoring and prosecuting abuses in healthcare markets. Creating an

environment where there are concerns over jurisdiction is likely to have a chilling effect on investigation in healthcare markets and supply chains. We therefore recommend that clause 3(5) of the NHI Bill be deleted and that the NHI Fund work together with the Competition Authorities to benefit from the alignment between the two legislative schemes.

The implementation of Health Market Inquiry recommendations in the interests of NHI

126. As noted above, the final report of the Competition Commission's Health Market Inquiry makes clear the need for reform of the private health sector. Such reform, if undertaken, could start to build towards NHI through standardisation and quality monitoring. Several specific recommendations bear mentioning:

126.1. The establishment of standardised base packages of services by medical schemes, which could become the NHI base package;

126.2. The development of a supply-side regulator, the role of which could be expanded to include the public sector; and

126.3. Quality measurement piloting in the private sector, which could form the basis for the monitoring of quality of care across the health system.

127. Even with the most optimistic assumptions about the timeline for implementation of NHI, the private sector in roughly its current form should be around for at least another six years. The private sector cannot be left in a state of dysfunctional regulation for all this time. And implementing key Health Market Inquiry report recommendations would allow for the better quality and efficiency monitoring: lessons that could be applied by the NHI Fund.

128. Appropriate regulation of the private sector, in line with the recommendations of the Health Market Inquiry, could help rather than hinder the effective implementation of NHI and we propose the prioritisation of the implementation of these recommendations.

129. In addition, we urge parliament to consider the NHI Bill in conjunction with the Medical Schemes Amendment Bill, since these two pieces of legislation are complementary and interdependent. It is also clear that the NHI Bill has implications for the functioning of medical schemes. Considering the two Bills together will also allow for a fuller consideration of the implications of the Health Market Inquiry for NHI.

5. What health service users have told us about what they want from NHI

130. There remains uncertainty in the public domain about what NHI is and how it will help in improving access to quality health care services for all. In order to provide information about NHI and to provide a channel for ordinary people to make input before parliament on the Bill, we engaged in two processes:

130.1. TAC held two community dialogues in each of the seven provinces in which it has branches. One dialogue was held in a rural district and one in an urban district in each province. A total of 1280 people attended these community dialogues. The dialogues were not held to contest parliament's consultation process, but as a source of rich information for our submissions from TAC and community members who are public health care users and health advocates and as a way of informing TAC and community members about the NHI.

130.2. SECTION27 provided an opportunity for people visiting our website and attending meetings we hosted to express their views on three key issues relating to NHI: governance, transparency, and the testing of structures before legislating them.

131. We lay out the outcomes of these two processes below.

Community dialogues

132. Community dialogues were attended by between 31 and 148 people. Adequate notice was provided for dialogues and communication about the dialogues took the form of

posters, telephone calls, social media and door-to-door visits. Attendees ranged from community leaders, TAC members, gender activists and people with disabilities in the community. The dialogues were led by a TAC leader from the province who was knowledgeable about NHI, provided accessible information to attendees about what the Bill does and does not provide, and answered questions. The views of participants were elicited and the dialogue outcomes and inputs were recorded in reports. Where the reports were unclear, clarity was provided through telephone conversations with provincial managers. Details of the community dialogues held can be found below:

PROVINCE	DATE	VENUE	NUMBER OF PARTICIPANTS
Western Cape	25 October 2019	Isivivana	141
Western Cape	05 November 2019	Pine Trees, Plettenburg Bay	77
Mpumalanga	01 November 2019	Driefontein Community Hall	58
Mpumalanga	29 October 2019	Kanyamazane Community Hall	83
Limpopo	24 October 2019	Tabernacle of Grace Church	148
Limpopo	21 October 2019	Revolution Church	123
KZN	25 October 2019	The Napier Pastoral Centre	31
KZN	30 October 2019	Mabuyeni Community Hall	120
Gauteng	07 November 2019	Trinity Church, Boitumelo	79
Gauteng	24 October 2019	Phumula	90
Free State	29 October 2019	Allanridge	80
Free State	07 November 2019	Thabo Mofutsanyane	61
Eastern Cape	29 October 2019	East London, Newlife Location	69
Eastern Cape	07 November 2019	Port St John's	120

133. Input from participants can be categorised under the following themes:

133.1 **Source of funding for NHI** – the funding for the NHI Fund confuses people. One participant expressed their confusion as "if the current health system is also

financed by the Treasury, what will change?" Another said, "I am very happy about the NHI but I still want to know more about where the money is going to come from". Concerns were also raised in relation to the shifting of conditional grants, including the HIV conditional grant, into the NHI Fund. The major concern was that the HIV conditional grant is required to be used, among others, to educate people about the importance of safe sex, symptoms of HIV, and other important information about HIV/AIDS and STIs. The protected funding for HIV has assisted in reducing the number of people living with HIV, making treatment accessible, and employing prevention methods. With the shift of funding to NHI, it is not guaranteed that the HIV programme will be adequately funded.

133.2 **Accreditation** – participants raised questions about the criteria for accrediting healthcare facilities and healthcare service providers to provide services under NHI. Participants in rural areas and townships noted that public facilities under the current system are underdeveloped and lack resources such as ambulances, medication and practitioners. In townships like Thokoza, there is poor infrastructure and clinics are often overpopulated and understaffed. These conditions, according to these community members, could never comply with accreditation criteria, no matter how low the standards may be. One participant in the Western Cape commented ''At New-life there is no community clinic nor hospital, we depend on a mobile clinic for collecting medication and other healthcare services. If this does not qualify as a healthcare services facility, what will happen to us?'' Participants urged that the conditions in health facilities need to be improved before the NHI is implemented and contracts only accredited facilities, otherwise it is going to be more difficult for them to access healthcare services.

133.3 **Governance** – Participants raised concerns about so much power residing with the Minister because if the Minister has all these powers, he might not be transparent and accountable to the general public. They suggest that this part of the Bill be revisited and a more inclusive and representative process and structure be adopted. They suggest further that there must be more details about the criteria, terms and conditions for the appointment and removal of board members and the

dissolution of the board. Failure to do this, according to participants, will raise suspicions which will result in a distrust of the NHI. One participant, in Mabuyeni, KwaZulu-Natal, said, "there is a very high corruption rate in South Africa. I cannot just trust one person with so many responsibilities. The Minister is also a human being and giving him so much powers and responsibilities is not a good idea."

133.4 **Registration as a user of NHI** - Community members from remote areas in KwaZulu-Natal were concerned about the NHI registration process because some of them do not have house numbers or street names, and their post office which they use as a point of reference is in town. The exclusion of some foreign nationals from NHI was raised as a concern as it is at odds with section 27 of the Constitution which stipulates that healthcare services should be accessible to everyone. One participant from Ethekwini said, "There are many foreign nationals in our community, should they now fly back to their countries of birth for access to other healthcare services?"

133.5 **Community outreach and awareness programmes** - Most participants felt that the government has not done enough work to educate the general public about the NHI and its implications because very few of them understood what it is before the community dialogue was held. One participant from Ethekwini said "I did not know anything about the NHI, MaKhumalo is the one who took me to the TAC event where I was then introduced to the idea". They also felt that there was deliberate exclusion from the government consultations because there was no advertisement in neighbourhoods and public spaces.

Survey

134. From 18 – 29 November 2019, we ran a survey on the SECTION27 website. Information about NHI and our key concerns with the Bill was provided, and respondents were asked to choose between two options on each of three issues. Respondents provided their names and contact details before providing their responses. The survey was also made available in meetings that we hosted. The issues and options were laid out in detail and we provide below the options on which participants voted:

1. Governance
    a) Should NHI governance be decentralised? OR
    b) Should the Minister, as the politician with ultimate responsibility for the provision of health care services, retain the power to make all the appointments?

2. Transparency
    a) Should the public have insight into decisions and contracts? OR
    b) Should we let the NHI Fund make its decisions in a closed boardroom, largely out of the public eye?

3. Try before you buy
    a) Should we build in processes and principles for testing new structures before signing them into law? OR
    b) Should we put all our weight behind the structures outlined in the Bill?

135. 232 people responded to the survey and the results were as follows:

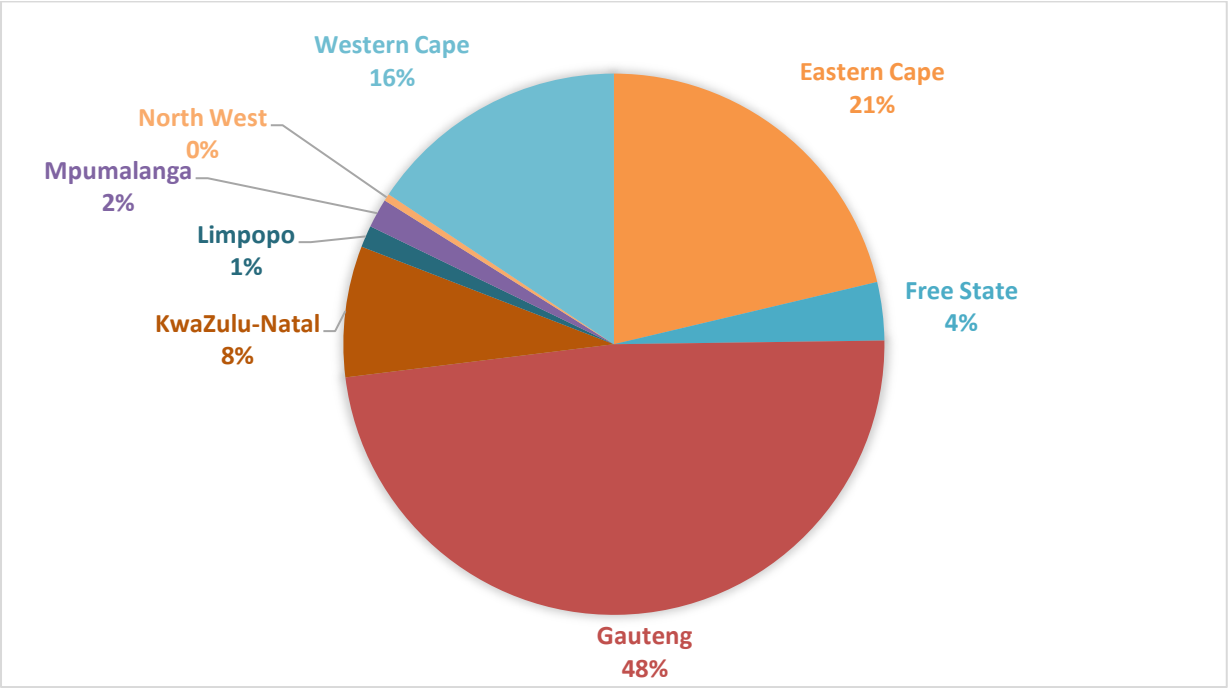

Figure 1: The highest numbers of respondents were recorded in Gauteng Province, Eastern Cape Province and the Western Cape Province respectively.

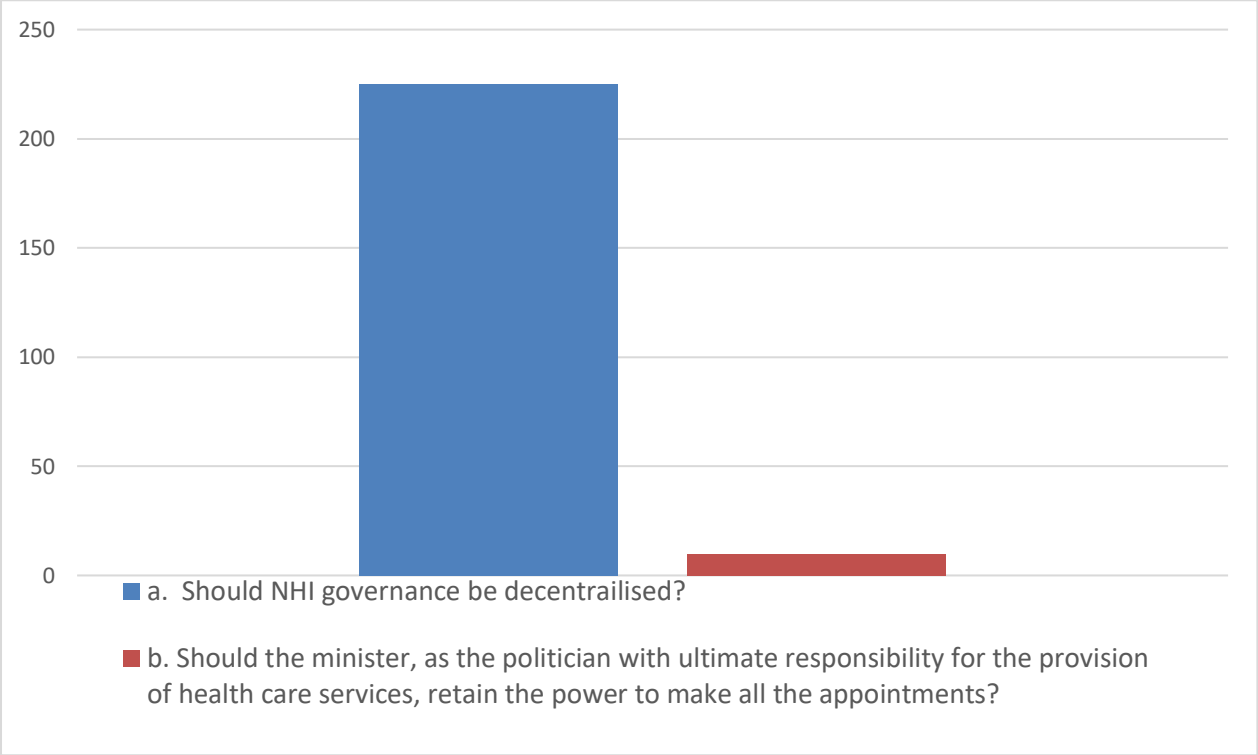

Figure 2: Of the 232 respondents; 225 (96.5%) were of the view that NHI governance should be decentralised from the Minister.

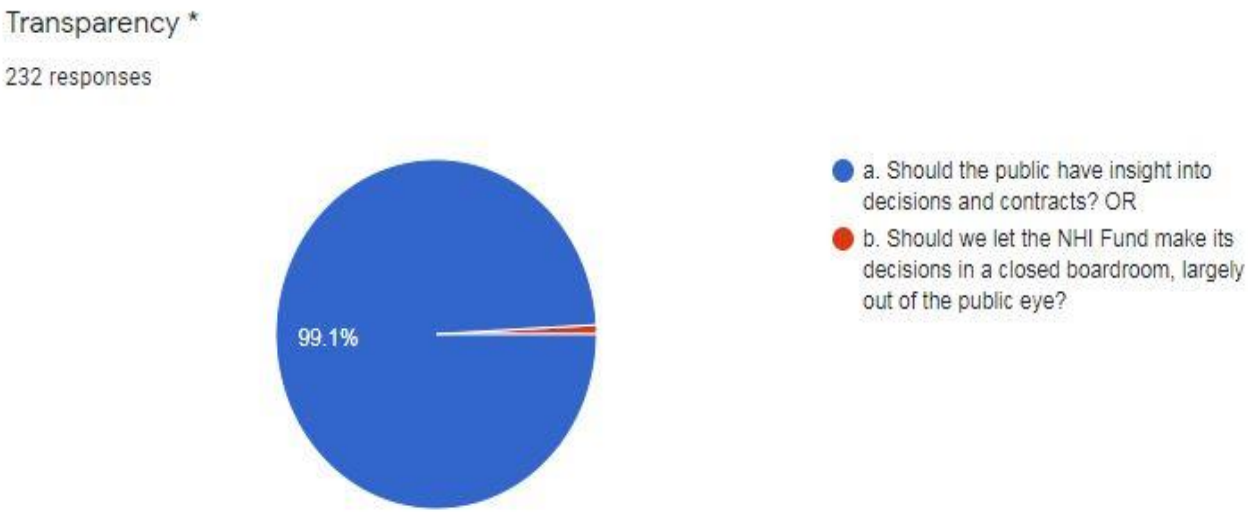

Figure 3: Only 0.9% of the respondents indicated that the NHI Fund should make its decisions in a closed boardroom, out of the public eye.

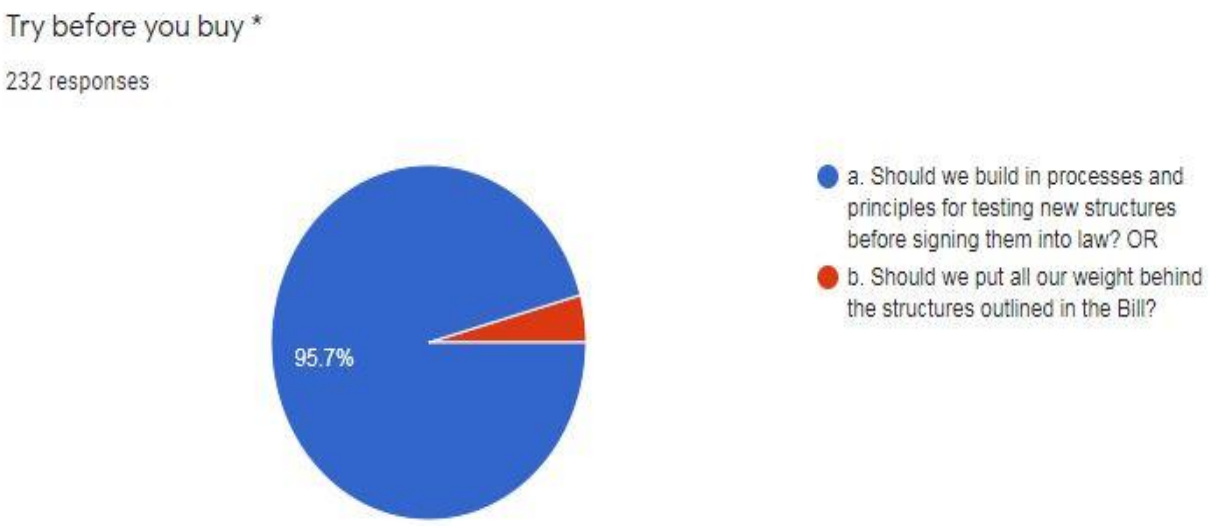

Figure 4: Of the respondents, 222 (95.7%) expressed the view that there should be processes and principles for testing new structures before signing them into law.

Conclusion

136. We trust that these submissions will be helpful to the Committee in its deliberations on the Bill and request an opportunity to make oral submissions at the oral hearings in Parliament.

137. Should you require any further information, please contact:

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