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INDEPENDENT MUNICIPAL AND ALLIED TRADE UNION
Social Transformation Through Sustainable Local Government

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The Director-General: Health
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By email: nhi@health.gov.za

Dear Sir

IMATU's COMMENTS ON THE DRAFT WHITE PAPER ON NATIONAL HEALTH INSURANCE (NHI)

We refer to the abovementioned matter.

IMATU respectfully submits the following comments, on behalf of our members, in response to Department of Health's (NDOH) invitation to submit comments on the draft white paper on National Health Insurance (NHI) published for public comment on 11 December 2015, and we welcome the opportunity to do so.

IMATU is a registered trade union organising within the local government sector. IMATU currently has approximately eighty three thousand (83 000) members in the sector, the majority of whom are members of medical schemes and receive an employer contribution towards their monthly medical scheme premiums. Our members, like most South Africans, have a direct interest in healthcare reform.

Our principal function, in making these comments, is to safeguard the rights of our members with respect to access to quality and affordable healthcare, the protection of medical aid benefits and constitutional rights to freedom of choice. The approach we have taken in commenting on the white paper is to:

- Highlight areas of agreement;
- Note areas of disagreement and outline the basis for such disagreement; and
- Make proposals as to how the white paper can be enhanced and improved.

General Observations

From the outset it must be stated that IMATU supports the concept of universal healthcare (UHC). We further agree that providing access to healthcare is constitutional imperative and we agree that the current healthcare landscape, which is beset with serious problems, is in need of urgent intervention. IMATU therefore supports attempts by the NDOH to remedy the situation and to create a more inclusive society in as far as access to healthcare is concerned. It is however specific proposals in the white paper that are problematic.

The current healthcare landscape in SA is a product of our unique history. Private and public health systems exist in parallel, operating as a two tier system of healthcare that has been described by some as inequitable, inefficient and a looming crisis. Private health care, run largely on commercial lines, catering to middle- and high-income earners who tend to be members of medical schemes, and to foreigners looking for top-quality surgical procedures at relatively affordable prices (medical tourism) is increasingly becoming more unaffordable every year. Public sector healthcare, on the other hand, is suffering from chronic underfunding, understaffing, poor management, deteriorating infrastructure and a range of other deficiencies. While general access to healthcare has improved, the quality thereof has deteriorated in both sectors.

The public health sector is under pressure to deliver services to about 80% of the population. However, most resources are concentrated in the private health sector, which cater to the health needs of the remaining 20% of the population. There are more than 400 public hospitals and more than 200 private hospitals but around 79% of doctors work in the private sector. In 2013, it was estimated that vacancy rates for doctors were 56% and for nurses 46%. Half the population lives in rural areas, but only 3% of newly qualified doctors take jobs there. All medical training takes place in the public sector but 79% of doctors go into the private sector.

Currently, 8.3% of GDP is spent on healthcare which is more or less in line with World Health Organisation (WHO) recommendation of 8% of GDP. However, the split is inequitable:

- **4.1%** spent on private sector which caters for 16% of the population (9 million people with financial means).

- **4.2%** spent on public health catering for 84% of the population (42 million people reliant on public health care).

Private health care is not without its shortcomings. Healthcare costs have increased by 120% over the last 10 years. SA has more than 110 registered medical schemes, with around 3.4 million principal members (and 7.8 million beneficiaries). Annually, medical aid premiums are increasing at rates much higher than inflation, which is a clearly unsustainable commercial model of health care provision with an added mismatch between services and costs and huge levels of over-servicing. Medical schemes premiums constituted 7% of average wages in the 1980's and has risen to 30% of average wages in 2008. Benefits are shrinking and medical schemes simply pass on increases to the end user i.e. the member. Very often members of medical aids who believe that they are sufficiently covered for all eventualities, subsequently discover that they are not as comprehensively covered as they thought. This is giving rise to the gap

plans market, i.e. additional insurance to cover costs incurred when medical aid coverage has run out.

Consequently, for the middle class, private healthcare is becoming increasingly unaffordable and more and more middle class people are systematically being squeezed out of the private health care system.

This is clearly an inequitable anti-solidarity model of healthcare. One would find it difficult to deny the raft of inequalities in our healthcare system and to think that we can continue on this basis regardless of the lack of equity and accessibility is disingenuous and naïve. To pretend that nothing need be done to rectify the current situation is shallow and evasive. IMATU believes that we have a historic opportunity to reform the healthcare system but these reforms should be guided by the Hippocratic Oath: “First, do no harm”.

The NHI white paper had been awaited with great anticipation in the four years since the NHI Green Paper was last published in August 2011. However, the white paper was received poorly as it did not introduce a great deal of new information compared to the Green Paper; and it further raised some concerns and uncertainties. The white paper appears to be long on rhetoric but short on specifics especially in crucial areas like funding and the role of the private sector. While proposals in the white paper are progressive and ambitious, they may be very difficult to achieve given the current healthcare landscape and our history of inequality.

That being said however, IMATU commends the NDOH for taking steps to deal with the inequitable access to healthcare and the looming crisis in both the private and public sectors. At the same time, we must also express, with equal strength, our deep concern that adopting the white paper proposals in their current form may ultimately hinder, rather than promote, the goals of equitable access to affordable quality healthcare.

Constitutionality of the NHI Proposals

The NHI represents a policy shift away from the current two tier system of healthcare and the market forces that dictate the operation of this system. However, the NHI can only operate under the constitutional framework and with due regard to the rights and obligations enshrined in the Constitution of the Republic of South Africa Act 108 of 1996.

Section 27 of the Constitution provides that everyone has the right of access to healthcare and it imposes an obligation on government to guarantee a fundamental right to healthcare and to provide equitable access to this right. The notion of treating healthcare as a commodity, as is currently the case, is wholly incompatible with such a constitutional right.

However, this obligation must be balanced with Section 18 of the Constitution which guarantees the individual a right to freedom of choice. IMATU is of the view that while the NHI may in some respects comply with the obligation to provide access to healthcare, it is doubtful whether it complies with the individual’s right of freedom of choice. The constitutionality of forcing people to belong to a system and then nevertheless requiring them to pay for that privilege poses fundamental legal problems.

In the USA, the Patients Protection and Affordable Care Act (Obamacare) has been subject to a number of legal challenges on this very basis, purportedly due to the law’s

many onerous mandates that's restricting choice and trampling fundamental freedoms. The law required individuals to purchase only federally mandated health insurance plans, known as the "individual mandate", and it provides for penalties for those who refuse to do so. The basis of the challenge therefore, was that it essentially violated freedom of choice. Furthermore, it limits consumer choice by mandating what services must be covered by insurance plans.

More than 4 dozen legal challenges have been filed against Obamacare since it took effect. While a number of US Appeals Court judgements found that the law indeed violated freedom of choice, these judgements were subsequently overturned by the US Supreme Court. The latest Supreme Court challenge, in the matter of *Burwell vs Hobby Lobby Stores*, who challenged the law on the basis that it violated religious freedom, proved successful.

IMATU is of the view that any NHI legislation is likely to suffer the same fate and its implementation is likely to be tied up for years in multiple court challenges. In fact, many organisations, in their comments to the green paper, already made veiled threats of legal action which is likely to be reiterated in their comments to the white paper.

Much like the individual mandate, the NHI essentially compels individuals to "buy" government mandated health insurance and precludes medical schemes from providing the same / parallel service even if an individual can afford to and prefers to seek medical care outside of the NHI structure. This substantially restricts the individual's freedom of choice in terms of what healthcare the individual deems optimal - if you like your doctor, you should be able to keep your doctor. Under the NHI, this is possible only if your doctor is contracted by the NHI to provide healthcare.

This aspect of the white paper proposals is atypical from a commercial standpoint and potentially in conflict with the Consumer Protection Act 68 of 2008, which has been specifically enacted to promote and encourage consumer choice, as well as the Competition Act 89 of 1998, enacted to provide consumers with competitive prices and product choices and to prohibit monopolistic / antitrust conduct, even on the part of government.

IMATU proposes that the white paper proposals be reviewed to promote more consumer choice in line with Section 18 of the Constitution in order to insulate them from legal challenges which are sure to follow.

International Experience

There are many lessons to learn from other countries who have implemented UHC. In fact, international experience shows that national health insurance systems worldwide are beset with serious problems of their own including:

- Increasing costs;
- Increasing demand;
- Rise of expectations;
- Changes in demographics (aging populations); and
- Constrained financial climates due to global financial crisis.

These problems have resulted in a rationing of care, deterioration in the quality of healthcare, elongated waiting times, financial deficits, restrictions of treatment, problems with immediacy of access and immediacy of treatment, poor health outcomes and national debates over whether the system can be affordable going into the future. In many countries, national health insurance systems are, in fact, starting to unravel. Healthcare reform, even in advanced rich countries, is complex because existing arrangements create long-term obligations, and the needs of today all too easily crowd out provision for tomorrow.

Other growing phenomena, such as where patients go from one doctor to another until they find one whose diagnosis they prefer (known as *nomadisme medical)*, and where patients modify their help seeking behaviour tending to use healthcare more frequently because it is free, are driving up costs to the system. Some governments have responded by re-introducing, and ultimately increasing, co-payments and attempting to limit physician reimbursements.

A number of countries have taken to rationing health care with a focus on cost curtailment. Canada, Great Britain, Norway, and Spain all heavily ration health care or have long waiting lists for care, while France and Switzerland have generally avoided waiting lists. In the USA, health care quality is suffering due to an overemphasis on cost containment. Even the British national healthcare system has been criticised for mismanagement which has resulted in long waiting lists and a “lottery” in deciding who gets life-saving drugs and surgery.

Canada, which is often held up as one of the examples of a successful well managed UHC systems in the world, have in recent times been forced to increase waiting times. According to the Frazier Institute of Canada, waiting lists in that country have increased from 9.3 weeks in 1993 to 18.2 weeks in 2014. Waiting times for hip, knee, and back surgery have increased to 42.2 weeks and neurosurgery to 41.2 weeks. These are clear indications that even well managed NHI systems are beginning to feel the pressure of overwhelming demand and high costs, thus gutting their effectiveness.

If these countries are already running into these types of problems with their financial resources and expertise, what can be expected to happen in SA? The difficulties experienced by developed nations that have attempted to provide free healthcare for all through a single payer model, as outlined above, should be a warning to SA attempting to go the same route. The NDOH, in our view, has not adequately taking these realities into account and the optimistic tone in the white paper is not, in our view, well founded.

Comparisons with Developed Countries and Middle Income Countries

The white paper, in order to make the case for the NHI, makes reference to the success of NHI systems in other countries. At **par. 49** it is stated that countries such as Brazil, Canada, Finland, Norway, Sweden, Thailand, Turkey and the United Kingdom have successfully implemented UHC systems.

The comparison with middle income countries appears to be more readily made, ostensibly on the basis that they share middle income status with SA. However, there are a number of socio economic conditions in these countries that differ vastly from our own. However, the white paper, in our view, has failed to take into account a number of considerations that do not support a direct comparison with these countries.

(2014) Country	Population	Taxpayers	Tax Base	Unemployment Rate	GINI Coefficient
Mexico	122 3 Mil	46.3 Mil	37.8%	4.75%	48.1
Thailand	68 Mil	20 Mil	29.4%	0.9%	39.3
Brazil	202 Mil	50.5 Mil	25%	6.8%	52.9
RSA	55 Mil	5.7 Mil	10.3%	26.7%	63.4

As can be seen from the above table, the middle income countries used in the white paper as a comparison where NHI has been successfully implemented, in fact have different socio-economic circumstances namely a higher tax base, lower unemployment rates and a lower Gini Coefficient (a measure of inequality). This creates a major problem for SA when it comes to funding the system especially in the long term as we simply do not have enough employed persons to fund the system through taxes. It is therefore a highly flawed comparison on which to justify an entire overhaul of our healthcare system.

Moreover, countries like Brazil have more than 2.5 million workers formally employed in the health sector, which represents about 1.3% of that country's population whereas SA have only 150 509 health professionals a population of 51 million which represents about 0.3% of the population. This represents a meagre 0.776 medical doctors per 1 000 population compared with Brazil's 1.891, China's 1.491 and the United Kingdom's 2.809, according to the WHO. We would need a rapid increase of investment in training of health professionals in order for SA to make par. In SA, medical student numbers have increased by 34% between 2000 and 2012 and this is encouraging but the NDOH should create more incentives to increase the training of medical professionals.

The comparison with first world countries who have implemented UHC is even less understandable. There are many obvious socio-economic differences which make it a flawed comparison. For instance, SA currently has a 50% lower employment rate than other countries who have implemented UHC. According to the World Bank, the ratio of Employment to Population figures of South Africa versus other developed countries that have implement UHC are as follows:

Country	Employment to Population Ratio
Australia	61.20
Canada	61.50
Denmark	58.30
Finland	54.30
France	50.20
Iceland	70.10
Japan	56.90
New Zealand	63.90
Norway	62.60
Sweden	58.90
United Kingdom	58.20
Average	***59.60***
South Africa	39.40

It is therefore wildly optimistic to implement the same UHC system as other countries with far better socio economic conditions and simply expect the same result.

Lack of Confidence in Public Institutions

The NHI is intended to reside under government control. This raises the concern that government institutions do not fully enjoy the confidence of the public. There are, in fact, high levels of dissatisfaction with service delivery from public institutions. With respect to healthcare facilities, Stats SA's General Household Surveys from 2011 to 2014 reveal the following as far as levels of satisfaction are concerned:

	2011	2012	2013	2014
Very Satisfied				
Public	61.9%	57.0%	60.6%	57.5%
Private	92.9%	91.7%	94.0%	92.2%
Somewhat Satisfied				
Public	21.7%	21.7%	22.0%	24.2%
Private	4.3%	4.8%	4.0%	5.3%
Dissatisfied				
Public	9.6%	12.7%	10.1%	10.1%
Private	1.9%	1.7%	1.2%	1.5%

As can be seen from the above table, given the current levels of dissatisfaction, the NHI is building a new system on poor and inadequate foundations. In addition to the public's lack of confidence, the success of the NHI is threatened by our public institutions' track record of scandal, bribery, corruption, mismanagement of resources, poor quality, bloated bureaucracies, the inability to handle social programmes, and rumours of a "state capture" by powerful business interests.

Moreover, the government's track record on the management of large scale public funds has been dismal. The point is well illustrated with respect to government's current management of the workmen's compensation fund. The NHI will basically be a large "medical scheme" to be managed by ministerial board much like the Compensation Fund. The Compensation Fund has an annual income of R8 billion and it has R52 billion in assets, most of which is administered by the Public Investment Corporation. In April 2015, in answer to a parliamentary question, the Director General of Labour reported that it had a backlog of 231 000 outstanding claims to the value of R23 billion, nearly half its asset value. Moreover, the implementation of a new electronic claims system nearly brought operations at the Compensation Fund to a complete halt last year as this system malfunctioned and the fund was unable to process its volume of medical claims resulting in a number of medical practices litigating in actions worth around R121 million in outstanding claims.

The Compensation Fund employs 1630 people who paid out R1.4 billion in medical claims last year. By comparison, a medical scheme such as Discovery Health, which has 5 times the number of employees, paid out 26 times the amount in medical claims. The proposed NHI budget would be 32 times larger than that of the Compensation Fund and total claims payable are likely to be 100 times more, not including paying of suppliers. The NHI Fund would therefore have to employ between 52 000 and 160 000 people. If the government is unable to run an R8 billion fund efficiently, how will it possibly manage a R256 billion fund?

A further example of government inefficiency, in this respect, is the Gauteng Department of Health. Pursuant to a question in the Gauteng legislature last year, the MEC indicated that it owed R296 million in outstanding claims to suppliers last year, in terms of which

R239 million (245 suppliers) were outstanding for more than 3 months and R105 million (203 suppliers) were outstanding for more than 6 months. This is despite the fact that the Public Finance Management Act compels them to pay suppliers within 30 days. It must be noted that the Gauteng Department of Health is, comparatively speaking, the more efficient provincial health department. It is quite possible that the situation at the other provincial departments is even worse.

Wastage that occurs in the NDOH at national and provincial level are in the billions and is regularly reported in the media. Moreover, negligence, high infant mortality rates, botched medical and surgical procedures and other horror stories are also regularly reported. The Gauteng Health MEC has recently disclosed that the number of negligent acts in hospitals in the province has doubled in the last 5 years. The recorded number of serious adverse events significantly increased in a one year period from 239 in 2011 to 373 in 2012. Medical malpractice claims against the NDOH amounted to around R22 billion in the last financial year. The NDOH Contingent Liability Fund for medical malpractice insurance stands at R24 billion as at 2016, as a direct response to increases in such claims.

These failures in the NDOH, the Compensation Fund and the Gauteng Department of Health do little to inspire confidence that the government will be able to administer the NHI effectively. The moment that the NHI fund ceases to pay claims efficiently, and on time, is the moment that the whole system will collapse. Doctors and other service providers will simply stop providing the services needed under the NHI and seek greener pastures in other countries where their skills are in high demand.

The fact is that legislation alone cannot combat poor management, underfunding and deteriorating infrastructure, which together result in underperforming institutions. The poor quality of these institutions has proven to be a major barrier to access – and could be a major obstacle in the successful implementation of NHI.

Readiness of Healthcare Facilities

At **par. 219** it is stated that the. NHI will provide coverage to quality health services for all South Africans. Therefore, all health facilities are required to comply with national norms and standards for quality. It is expected that all facilities must be fully compliant with the core standards of quality at all times.

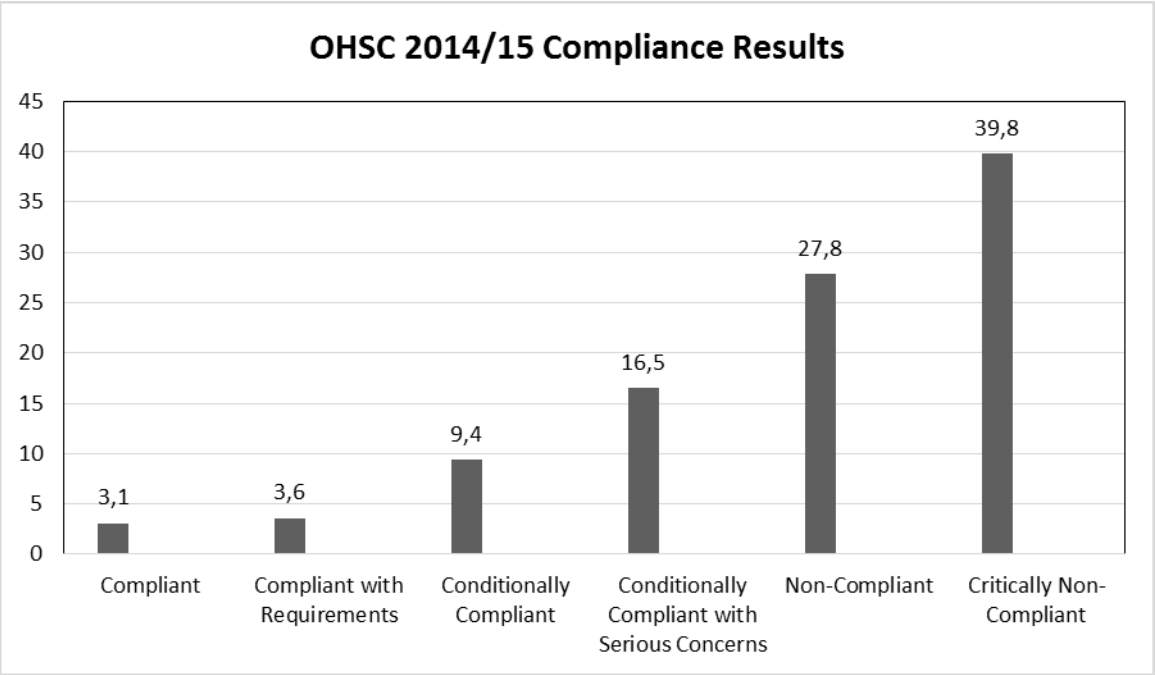
IMATU supports the notion of improving the quality standards at healthcare facilities. This process must first be completed before NHI can commence. The NHI must be built on a proper foundation. IMATU is however concerned that the current state of public health facilities are not up to a standard that can support a successful NHI programme.

In 2013, the government published a report on a Baseline Audit for Government Health Facilities. Around 3880 facilities were audited during this process. Of these, only 32 complied with infection control guidelines and only a quarter of clinic staff had a positive and caring attitude. In terms of this report, 93% of maternity facilities did not have the necessary equipment to ensure mother and baby treatment safety and only 2 facilities could guarantee general patient safety.

In addition, the Office of Health Standards Compliance (OHSC), established by the NDOH in terms of the National Health Amendment Act 12 of 2013, to extend quality

healthcare to all by ensuring that healthcare facilities comply with minimum health standards, conducted a national performance audit, in 2014, on 417 public healthcare facilities and the following results were recorded:

2014/15 OHSC National Performance Audit



As can be seen from the above table, the audit revealed that only 3.1% of facilities were compliant with the minimum health standards, another 13% of facilities were conditionally compliant and 67.6% of the inspected facilities were Non-Compliant or Critically Non-Compliant. In the NHI white paper it is stated, at **par. 217**, that "Health facilities that meet nationally approved standards will be certified by the Office of Health Standards Compliance to render health services". If the OSHC performed its mandate with these inspection results, only 16% of public health facilities would currently be operational in the NHI.

At **par. 75** of the white paper, it is stated that the audit has further revealed that there are quality problems in the areas of staff attitudes, waiting times, cleanliness, drugs stock outs, infection control and safety and security of staff and patients. In addition, significant increases in utilisation due to the high burden of disease and increased patient loads have further compromised the quality of care. This clearly demonstrates that the majority public healthcare facilities are far from ready to cope with the ambitious NHI proposals. Significant investments in infrastructure, resources, management and human resource development will be needed before these institutions will be compliant and even close to ready for the NHI.

Fate of Employees at Non-Accredited Healthcare Facilities

IMATU is concerned that he fate of employees at facilities for e.g. clinics which do not meet the standards of accreditation are unclear. Will these facilities be closed and will employees be transferred to other facilities or retrenched? These are hugely important

labour relations considerations for IMATU members who are employed in healthcare facilities at municipal level and this is not dealt with at all in the white paper.

Expansion and Re-engineering of PHC's

IMATU welcomes the proposed expansion of Primary Healthcare Facilities (PHC's) to 4000 wards. IMATU also supports the re-engineering of primary healthcare which involves measures such as the reintroduction of school nurses, employing community health workers to go house-to-house to find people at risk, and improving the services offered at clinics. The aim being to catch health problems before they escalate, requiring more costly hospital treatment.

IMATU is however concerned that there is no specific plan as to how these PHC's would function under the NHI. Take human resources, for example: if you want to look after 55m people and give everyone primary health care, with X consultations a year, then how many nurses and doctors do you need? You need an audit, a model to predict the number you need so you have an idea of the gap. Without that you cannot possibly know what the budget will be. The white paper is seriously lacking in detail in this respect.

IMATU proposes that PHC's be kept at municipal level and be funded from the NHI. Existing ward infrastructure systems can be utilised alongside community networks to ensure fast and effective service delivery. Municipalities and their respective wards are known entities with existing reporting and servicing structures in place. Municipal Ward-based Primary Health Care Outreach Teams will be able to access these existing structures in order to systematically visit, identify and treat members of the public. PHC facilities could take a number of forms such as municipal clinics, satellite health care stations, roving health care workers etc. The premise remains that PHC should be accessible to the community and the first port of call if there is a health care related concern. Improved accessibility to health care at a municipal level will be particularly helpful in more rural municipalities, where the larger health care facilities are further away. While collaboration between various departments will need to take place to ensure that the objectives of both basic health care and social wellbeing are being met, the function of PHC provision at a municipal level should fall under the ambit of local government. This is an important issue in respect of which IMATU will continue to engage with the NDOH in the long term.

Integration of Private and Public Sectors into the NHI

Cleary the idea is that public health institutions once accredited by the OHSC will form the backbone of the NHI. However, as previously stated, no more than 16% of these facilities, in fact, meet the criteria for accreditation. Therefore, it can be assumed that around 16% of public health facilities will be expected to serve the entire population of SA if the NHI is implemented in terms of the proposed 14 year time-line. Indeed, provinces such as the NC and the EC would have no healthcare services whatsoever.

The role of the private sector is not clearly set out in the white paper. The NHI envisages the use of private practitioners at PHC level and hospital level. The white paper states that the NHI Fund, in consultation with the Minister, will determine the pricing and reimbursement mechanisms and those practitioners who wish to contract with the NHI must comply with these mechanisms. Payment of uniform capitation fees regardless of whether in public or private sector (p 21-24) is, according to the white paper, to result in

an equalisation of fees. However, this equalisation is not, in fact, equitable. Public sector doctors do not have overheads as government pays for it while private sector doctors do have such overheads. Failure to incorporate these factors into the pricing mechanism is likely to discourage buy-in from private health care professionals.

This NDOH's approach is already beset with difficulties in the pilot phase where contracting private GP's has been met with limited success. Currently the OR Tambo District EC has 1 private GP, Pixley Ka Seme MP has 10 private GPs and Gert Sibande District MP has 35 private GPs. Only 256 posts have been staffed out of 600 in 11 Pilot Districts. Long hours, equipment failure and lack of leadership are some of the reasons doctors are finding it hard to stay.

The 11 NHI pilot sites have been allocated R4.5 billion over the medium term. Within the funds allocated for pilot sites, R912.7 million has been set aside to pay for private sector healthcare professionals who contract with the state to work in NHI pilot sites, and to continue piloting a model for distributing chronic medicines outside health facilities. However, GPs feel that the R381 hourly rate being offered by the NDOH in the pilot districts is far too low and are declining to work in the pilot programmes. It is hard to imagine how specialists, already in short supply even in the private sector, will be persuaded to work harder for less in a single health system – particularly if they are used to a certain income level. In fact, the white paper is completely silent on how specialist services will be incorporated into the NHI systems. If specialists do not buy into the NHI, they are likely to leave the country for greener pastures where their skills are in high demand.

In 2013/2014, NHI pilot districts underspent around R291 million of its allocated funds, and in 2014/2015 underspending amounted to R305 million. Failure to attract private sector practitioners and skill and underspending of allocated funds are clear failures that can be expected once the NHI is implemented. The NDOH's own NHI Pilot Project Progress Report has identified the following as its key challenges:

- partnering with the private sector;
- improving governance and accountability; and
- investing in human resource development.

The fact is that the NDOH, in the pilot phase of the project, is already finding it difficult to integrate the private sector into the NHI, and there doesn't seem to be any serious plan on the table to resolve these issues. In fact, the white paper does not explicitly review the impact of the 11 NHI pilot sites. It barely alludes to the pilot sites, yet a year ago it was apparent that its plans for recruiting private sector GPs to work in its clinics had run into such trouble, and attracted so few doctors, that National Treasury slashed a three-year grant earmarked for this purpose. IMATU has serious doubts that integration of the private sector will be possible under the NHI, or that the NHI will be able to function effectively unless the key challenges, as identified, are dealt with immediately and drastic changes are implemented.

At the unveiling of the white paper, the Minister of Health indicated that 80% of specialists are serving 16% of the population in the private sector and that this inequitable distribution is unacceptable. Actual research figures published by Econex in 2013, which was also used in the NDOH's own Human Resources for Health publication, shows that between 28% and 38% of residents in South Africa utilise private healthcare.

41% of specialists work in the public sector, with 59% working in the private sector. The data in the white paper which is used to make the case radical changes to the healthcare system in South Africa is thus incorrect.

IMATU is of the view that the NHI can only work if viewed as a public-private solution. However, one cannot help but to detect a tone of hostility and/or apathy to the private sector as far as participation in the proposed NHI is concerned. The white paper also fails to articulate a way of drawing on the expertise and resources in the private healthcare sector. In our view, public-private partnerships have the potential to combine the best attributes of both sectors. They require good governance and a strong regulatory environment in order for the government to manage costs effectively.

Basket of Services

At **par. 132** the white paper promises a comprehensive package with a strong focus on PHC but it will not be PMB based. This is because PMB's cover a limited number of health conditions, are essentially hospi-centric without fully addressing the burden of disease.

The benefits to be provided by the NHI is described in the white paper as an "all-encompassing basket of services" and on the surface it does look like that. However, IMATU has a number of concerns with this statement:

- At **par. 125** it is stated that NHI will not cover everything for everyone. This is a very worrying, almost a "fine print" exclusion, especially considering that the NHI requires mandatory participation and medical schemes may not provide parallel services. The white paper should more clearly spell out what services will not be provided and not rely on a statement which implies a ministerial discretion in respect of services to be excluded.

- At **par. 134** it is stated that therapies that are deemed to have little impact on positive health outcomes and that are expensive will not be covered. Dread diseases, rare diseases like haemophilia, which is very expensive to treat and treatments which merely prolong life but does not cure the disease most likely to fall under this exclusion.

- At **par. 375** it is specifically stated that the NHI may decline payment for rare conditions or conditions nor covered until the NHI. No justification is provided for the exclusion of rare conditions. Reference is also made to other conditions which may not be covered, which is not specified. In this respect, the basket of services in the NHI cannot be said to be all encompassing.

- At **par. 150** it is stated that patients will have to pay out of pocket for services not covered or get complementary medical scheme cover. However, because it is a pre-existing condition, it is likely to be subject to long waiting periods and indigent persons will effectively have no other alternatives.

IMATU is of the view that this crucial element of the proposed NHI has far too many exclusions and is accompanied by too many vague and general statements regarding services that will be excluded. It would be tantamount to a "bait and switch" if these exclusions are only fully clarified once everyone has signed up for the NHI.

Even if a comprehensive package is specified and initially implemented, how long can this, in fact, be guaranteed? As already seen from international examples it has led to rationing i.e. reduction of basket of services in the long run as cost cutting measures become necessary. It is inevitable that the NHI will eventually suffer the same fate.

The Future Role of Medical Schemes

The Green Paper, in 2011, originally proposed a system in which everyone would contribute to NHI, but this would not be their only choice, as medical schemes would continue to operate alongside the NHI. It was assumed medical scheme membership would eventually diminish as the various tax increases required to fund the NHI would make medical schemes less affordable, and the quality services offered under the NHI would diminish the need for medical schemes. The white paper, however, articulates a much more hostile view towards the medical scheme industry. At **par. 397**, it seeks to eliminate duplicative cover and double dipping. Accordingly, medical schemes will become complimentary and may not duplicate the services provided by the NHI. In other words, medical schemes will only be allowed to provide services not covered by the NHI, such as for example, elective or cosmetic surgery.

Implicit in the white paper is an assumption that the R140 billion currently spent on medical schemes, along with the R21.7 billion out-of-pocket spending on private health care and R4 billion on health insurance, can and should be re-directed into NHI. This is likely to lead to drastic reduction in number of schemes also reduction of scheme members due to increased tax burden and consequent unaffordability of medical schemes in this environment. Premiums will have to be increased due to smaller risk pool and schemes will be reduced to covering only rare diseases and elective / cosmetic surgeries. It is, in fact, highly unlikely that medical schemes will be able to continue to exist in the NHI environment.

The Minister has expressed conflicting views on the matter, in the business day article of 1 February 2016, he stated that medical aid schemes have a right to exist and should be able to provide parallel services so that it wouldn't intrude on the individual's freedom of choice. The Minister however subsequently reversed his position, during his submission to the Competition Commission on 1 March 2016, stating that medical aid schemes will not be allowed to provide parallel services. The Minister's ambiguity in this respect, indicates, at least implicitly, that there is a difference of opinion in the NDOH on what the role of medical schemes should be within the NHI environment and perhaps the NDOH have not yet settled on a single best model in this respect.

However, medical schemes are not without problems in the South African healthcare context. The number of medical schemes in South Africa has decreased from 133 to 87 over the last nine years with the number of beneficiaries steadily increasing from 6.6 million to 8.7 million (31.8% increase). The number of members belonging to a medical scheme is 3.9 million in 2013 compared to 2.8 million in 2003 (39.2% increase). Private healthcare is becoming increasingly expensive due to healthcare cost inflation in excess of CPI, increasing expenditure on new technology, scare skills and increased utilisation of services. The affordability of private healthcare is impacted by the level of benefits offered, level of contributions and tax relief (medical aid tax credits).

The medical scheme contribution tax credits increased in line with inflation of 6% over the 2013 to 2014 period, while the average medical scheme contribution increased by 8.9%. Since medical scheme contributions have increased at a much higher rate, the cost of private healthcare is an even larger burden for members of medical schemes. This will lead to affordability constrains for members who are already financially stretched in covering their scheme contributions.

Does this mean that medical aids should be abolished, as the white paper is effectively proposing? IMATU does not believe so. The Competition Commission inquiry into private healthcare costs should have a major impact on the affordability of private healthcare and, by implication, medical aid premiums and provision of benefits. It may be that medical schemes need to be regulated more strictly in respect of premium increases and provision of benefits but they should be allowed to remain as a safety valve in case the NHI fails to get off the ground or function effectively.

Moreover, the structuring of the NHI so as to deprive medical schemes of the ability to provide services and to structure their affairs accordingly, as is currently the regime under the Medical Schemes Act 131 of 1998 ("MSA") may constitute an unlawful infringement of the right to property that is guaranteed by section 25 of the Constitution. In terms of the MSA, medical schemes constitute juristic entities and are required to run their affairs accordingly and to be held accountable in terms of the MSA. The effective removal of the ability of medical schemes to provide benefits and charge for such benefits accordingly may constitute an unlawful infringement of medical schemes' right to property as well as medical schemes' right to practice a trade, occupation of profession in terms of Section 22 of the Constitution.

In IMATU's view, the future role of medical schemes need to be investigated further as the current white paper view of medical schemes, being complimentary to the NHI, when fully implemented, requires careful assessment based on constitutional and economic realities as outlined above. The majority of other publically financed, UHC based health systems in the world have medical schemes/health insurers operating as supplementary structures to these health systems and IMATU submits that the NHI proposals should follow this approach.

NHI Costing

Inexplicably, and rather audaciously, the white paper states (at **par. 250**) that "focusing on the question of what NHI will cost is the wrong approach". In IMATU's view, how much will the NHI cost is the key question. It was expected that the 90-page white paper document would finally provide clarity on how the NHI would be financed and how much would be needed to run this ambitious plan. However, the costing of the proposed NHI in the white paper does not appear to have been adequately done. Shortcomings in the costing include:

- Uncertainty over sources of funding;
- Use of unrealistic and outdated figures; and
- No evidence of National Treasury's assessment of the costs.

In terms of the white paper, the cost of NHI has been estimated to be R256 billion by 2025 (in 2010 monetary terms), which is approximately 63% higher than the current national budget allocation toward healthcare. This estimate cost is based on assumptions

of future health service utilisation levels, service provider availability, cost of delivery, the benefit package design and an economic growth projection.

At **par. 271** the white paper acknowledges that economic growth is needed to ensure an expansion of the tax base. But the white paper relies on an economic growth projection of 3.5% a year (a rate last attained in 2011). This figure seems fantastical given that current economic growth is stuck at around 1.5% with an IMF forecast of 0.7% average growth for this year, coupled with a recent ratings downgrade of two notches above sub-investment grade, with a very real risk of slipping into recession as well as an imminent path to junk status. The country has been warned that if it fails to curb public spending, another ratings downgrade will follow, with an array of negative financial consequences. In fact, introducing the NHI under current fiscal constraints is an issue the credit ratings agencies have already flagged as a concern. In IMATU's view, an NHI proposal that does not take these economic realities on board is reckless. On the other hand, few countries implemented universal health care when their economies were in good shape. Japan started in 1961 when their economy was in a bad state, Britain started in 1948, three years after World War 2, when it was in very poor financial state and, in the US, Obamacare was instituted while the country was still reeling from the 2009 recession.

IMATU is concerned that the white paper fails to address the economic effects of the implementation and imposition of the potential revenue sources on the average South African and the effect of the imposition of such revenue sources on the country at large in the current and medium-term economic circumstances in which it finds itself. It is also surprising to note that, at this stage of the process, the 2010 figures are still being used and why it is that NDOH still don't have a more accurate idea of the costs involved especially since the figures present the country with the second-biggest fiscal risk after nuclear energy. It seems unlikely that the assumptions used in the white paper are feasible, thus invalidating the estimated cost. Surely the costs of what it would take to run the NHI is one of its most crucial factors, yet little effort appears to have been made to get a more realistic up to date projection that is backed up by National Treasury assessments.

Lack of Clarity and Finality on NHI Funding

The white paper states that R225 billion will be required to fund the NHI but it is still unclear how the amount will be raised under the current economic climate and small active tax base that exists in South Africa. The white paper states, at **par. 293**, there is uncertainty about the funding requirements for NHI because they depend on public sector improvements and medical scheme regulatory reforms "that have not yet been fully articulated".

The white paper states that the financing requirements for the NHI could potentially require additional tax revenue of R71.9 billion (in 2010 prices) by the financial year 2025-2026. The white paper also states that, by 2025, the NHI funding shortfall should be financed by additional tax revenue that amounts to R108 billion, R71.9 billion or R27 billion (all amounts in 2010 monetary terms) should the 2010 public health budget grow by 2.0%, 3.5% or 5% per annum, respectively. These funding shortfall estimates are significant in size as they represent 69%, 46% and 17% relative to the current national budget allocation towards healthcare, respectively. Three potential sources of tax revenue are identified in the white paper for funding the shortfall: increasing VAT, a

payroll tax, and a surcharge on personal income tax with increases in personal income tax being the primary contender for funding the NHI.

Five alternative scenarios, using the three potential sources of tax revenue, are outlined in the white paper in order to raise R71.9 billion each with different combinations of taxation sources and with a phased-in approach over the implementation period, but the final tax design has not been included in the white paper. Nor were there any scenarios outlined to raise the R108 billion or R27 billion potential funding shortfalls.

Two of the tax scenarios in the white paper propose that by 2016/2017 financial year both payroll tax and personal income tax be increased by 0.5%. Other two tax scenarios propose that only personal income tax be increased by 0.5% in the 2016/2017 financial year, while the final scenario proposes that only payroll tax be increased 0.5%. It is, in our opinion, quite clear that government will have no option but to increase payroll and/or personal income tax by at least 0.5% for the 2016/2017 financial year in order to fund the NHI, which will intensify the hardship of already overburdened taxpayers. However, this assumes that the 2010 public health budget will continue to grow by 3.5% per annum. There is therefore the possibility that the tax increases could be even higher than 0.5% should the public health budget growth be higher than estimated in the white paper.

Another contender for funding the NHI is a VAT increase. VAT is a regressive tax and may not be a sound option to finance the NHI. Whether rich or poor, the amount paid on a certain product as a percentage of its price is the same. The tax burden for a given product, therefore, forms a larger share of a poor person‘s income than that of a rich person. An increase in VAT will not only retard economic growth and exacerbate South Africa‘s chronic unemployment problem but will also raise inflation and increase inequality – precisely the opposite of the intention behind the proposed NHI.

The white paper was released during an economically uncertain time. High levels of poverty and unemployment means that healthcare will largely remain the burden of the state and given the current fiscal constraints confronting the government, there can be no doubt that taxpayers will be expected to contribute significantly towards the NHI. Yet the proposed financing mechanisms for NHI is anything but clear on the subject, which is surprising at this stage of the process. If anything, the figures show that the country may not be able to afford the NHI at this time, or even in the near future.

The Finance Minister has recently vowed to prevent another ratings downgrade, which indicates strongly he will not let anything through that will increase government expenditure or cause uncertainty about future spending. In the short term, it is inconceivable that tax increases would be allocated to anything other than narrowing the budget deficit in order to avert a further ratings downgrade. In the 2016 budget speech, it was revealed that the current budget deficit is a staggering R139 billion which contributed significantly towards the ratings downgrade. Rating agencies subsequently flagged a lack of detail in the budget on how the deficit would be reduced. Moreover, SA’s debt to GDP ratio has increased to 50% of GDP from levels of about 26.5% in 2009. The Treasury is more optimistic on economic growth rate this year with a forecast of 0.9%, but Moody’s projected a mere 0.5%. The business confidence index (at 36 — a historic low) has collapsed to levels last seen during the 2009 recession. Against this background, the NHI tax funding proposals cannot be seen in isolation as other tax increases to narrow the budget deficit, and other tough financial decisions to kick-start economic growth may also be looming in the near future for already overburdened taxpayers.

The Davis Tax Committee, in its First Interim Report on Macro Analysis, released in December 2014, stated (at page 95) that “Ideally, NDP priorities should be financed from increased tax revenues generated as a result of stronger economic growth, improved tax compliance, expenditure reprioritisation, elimination of inefficiency and corruption and increased effectiveness of public spending.“ In our view, the committee sets out a fiscally responsible path towards establishing the NHI and the NDOH would do well to heed these recommendations. IMATU fully agrees with the committee’s recommendations as aforesaid and we would submit that this ought to be the starting point in the approach to funding the NHI.

The committee further added that, should the tax system be required to generate additional revenue, it should bear in mind the progressivity of overall tax system, trade-offs associated with the choice of tax mix should be carefully considered in terms of their impact on inclusive growth and the tax system must not be used to offset pathologies in other parts of the system (e.g. in respect of property rights or labour market challenges). The committee stated that where elements of public policy are unclear or problematic, these should be dealt with at source and not compensated for by the tax system. IMATU fully agrees with this statement.

The lack of finality on funding proposals makes it difficult to engage effectively on these issues prior to the commencement of the legislative process which is expected to follow the white paper. It is also highly problematic that the treasury document, meant to support the funding proposals, was not released during the comment period for the white paper despite promises by the Finance Minister, in his 2016 Budget Speech, that it would be done. It is unrealistic for the NDOH to expect the public to make meaning inputs on funding proposals that lack clarity and finality and is not backed up by credible treasury assessments. To further complicate matters, the public consultation period ends well before the six working groups appointed by the Minister to thrash out the missing details are due to complete their work, in mid-2017.

There is also no clarity on how the NHI funding proposals will affect medical aid benefits provided by employers. Currently, a number of employers subsidise medical aid premiums. If the NHI is to be funded by an increase in payroll tax or VAT increase, it may be difficult to retain the employer subsidy as employers may not be prepared to subsidise a tax liability. This issue affects our members directly as the majority of our members receive a medical aid subsidy from their employers.

Alternative Approaches

As stated before, IMATU supports the concept of UHC, in principle. We however believe that there are alternatives to the NHI that should be explored. The WHO holds the view that when it comes to UHC, every country must adopt its own UHC solutions based on its own unique circumstances.

IMATU agrees that this is a sensible approach. SA is unique in terms of unique social problems due to our unique history. We need a solution that is unique to SA to deal with our particular problems and we cannot simply rely on a cut and paste job of what has worked in other countries. There are elements of NHI that can work, for example reduction and regulating of the cost of private healthcare, and the upgrading and improvement of public healthcare and these elements should be implemented without necessarily overhauling the entire system of healthcare.

Instead of the NDOH's big bang approach, a more progressive incremental strategy may be more effective in the long term. The first question that the NDOH should address is: What is the best way for the poor to gain access to quality healthcare? The first step should be to stabilise the healthcare system as a whole and, by doing so, address the following main areas:

- **Upgrading and improving public healthcare**: Upgrade public healthcare facilities and improve the management thereof. Allow the process of accreditation by the OHSC to be completed. This will allow the unemployed, indigent and low earners to gain access to quality affordable healthcare.

- **Reducing and regulating the cost of private healthcare**: Allow for the Competition Commission's market inquiry into the cost of private healthcare to be completed. Price control for private medical care similar to current pharmaceutical price control, should be instituted. Specific attention should be paid to regulating the cost of specialists and the cost of private hospitals. This could alleviate some of the pressure on the public sector as more people will be able to afford private medical care.

With this approach, the operation of medical schemes can no longer be left to market forces alone. The continuing upsurge of private health care costs and above inflation medical aid premium increases detracts significantly from such a notion. Medical schemes should be regulated more strictly in respect of premium increases as well as limitation and gradual erosion of benefits. The NDOH should regulate benefit provision and regulate the levels of administration costs similar to what is currently proposed by National Treasury in respect of retirement funds.

In IMATU's view, the NDOH should also consider subsiding the medical aid premiums of the poor rather than insuring the whole nation. In this regard, the Dutch System of universal health care represents a viable alternative to the NHI. In terms of this system it is compulsory for all citizens to join medical schemes which compete in the market. The state subsidises the premiums of the poor and low earners in terms of a means test. In a SA setting, the state can fund medical aid premiums of the poor or provide coupons to purchase services from the private health sector, which is essentially the same it currently uses to provide housing for the poor. This is in line with the broad and growing international trend to move away from centralised government control in the provision of UHC and to introduce more market-oriented features.

Conclusion

There can be no doubt is that SA urgently needs health-care reform. Despite our status as a middle-income country, the health system is buckling under a huge burden of infectious diseases such HIV and tuberculosis, non-communicable diseases, high rates of maternal and infant mortality and very high levels of injury and violence. There are, however, sharply differing views as to whether NHI is the right medicine for SA's crippled health system.

The NHI white paper has clearly set out an ambitious plan to provide universal healthcare coverage to South Africans, but some critical information, which is fundamental to the success of NHI, is still outstanding. Furthermore, the cost of NHI is based on an

economic outlook that is wildly optimistic. It is also clear that the National Budget will require significantly higher tax revenue to implement this new health system, increasing the burden on taxpayers.

At the heart of the matter is the fact that the NDOH is fundamentally opposed to what they refer to as the commodification of health care, and given that we have a constitutional right to healthcare, this approach should be supported. IMATU does not oppose the idea of social solidarity provided that it is achieved without a decline in the quality of healthcare, freedom of choice and an upsurge of financial burdens on the taxpayer already taking financial strain due to high costs of living. Stated at its most benign, the white paper proposals, in their current form, are at variance with the aforementioned notions and this makes it difficult for IMATU to express full and unconditional support the NHI proposals at this time.

In our view, as well intentioned as the proposals in the white paper may be, in their current form, they may well result in the following consequences:

- Driving medical professionals out of the country;
- Reducing the quality of healthcare provision in SA;
- Creating a bureaucracy incapable of handling the huge volume of claims; and
- Impose unnecessary and intolerable financial burden on already overburdened tax payers.

Against this background we would urge the NDOH, before settling on a final design of the NHI, to conduct a comprehensive review of all available empirical literature as well as evidence from other countries who have implemented UHC and to consider this issues outlined in this position document as it proceeds to the next stage of crafting a final white paper.

We appreciate this opportunity to make submissions and we would be pleased to further discuss constructive approaches to these issues with the NDOH.

Thank you for your consideration of our comments. If you require any further information, clarification or any other possible assistance, please contact the writer hereof.

Yours faithfully

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Johan Koen
General Secretary