SUBMISSION TO THE SELECT COMMITTEE ON HEALTH AND SOCIAL SERVICES, NATIONAL COUNCIL OF PROVINCES, ON THE NATIONAL HEALTH INSURANCE (NHI) BILL, 2019 [B11 B – 2019]

(As per National Assembly 12 June 2023)

15 SEPTEMBER 2023

BUSINESS UNITY SOUTH AFRICA ('BUSA') AND BUSINESS FOR SOUTH AFRICA ('B4SA') SUBMISSION

Contents

1 Executive Summary 3
2 Introduction and Overview 5
3 BUSA and B4SA – Role and Position on equal access to healthcare 12
3.1 Role 12
3.2 BUSA/B4SA Position: Strengthening the South African Healthcare sector. 14
4 Expected Economic Impact of the NHI Bill 16
4.1 Background to healthcare financing in South Africa 16
4.2 Financing Issues in a fiscally constrained environment 17
4.3 Impact on provincial allocations 21
4.4 Economic impact and the consequences of policy uncertainty 22
5 The effect of section 33 is counter-productive to the goal of UHC 25
5.1 Background on the current healthcare financing environment 25
5.2 No clear rationale for section 33 26
5.3 No evidence to indicate that a single-purchaser model is the best for South Africa. 28
5.4 Unintended consequences of section 33 28
5.4.1 Consequences of the tax proposals on the disposable income of consumers, particularly lower income earners. 28
5.4.2 Adverse consequences on the supply of healthcare professionals 29
5.4.3 Loss of current cross subsidies of pharmaceuticals and medical equipment in the public sector by prices charged to the private sector 32
5.4.4 Impact on the rights of individuals to purchase healthcare cover 32
5.4.5 Ability to attract investment into the healthcare sector 32
5.5 Legal Concerns 34
5.5.1 Limitation of constitutional right to access to healthcare 34
6 Cross-subsidisation between private and public sectors will guarantee the sustainability of the healthcare system 35
7 Definition of milestones and phased implementation 37
8 Governance and structures 39
9 Immediate opportunities for advancing universal health coverage (UHC) 41
10 Recommendations 41
10.1 Specific recommendations: 42
11 Annexure: 45

1 Executive Summary

- Business Unity South Africa (BUSA) and Business for South Africa (B4SA) recognise the importance of universal health coverage (UHC) for the future success of our country and our economy. It is essential that every person, rich or poor, has equal access to quality and affordable health care, as provided for and protected in section 27 of our Constitution. South Africa needs an NHI system that addresses the current unequal health care system, but that is also sustainable and affordable for the country and all her people. To do this will need the active involvement of both the public and private healthcare sectors.

- Consequently, we are making this representation to the Select Committee on Health and Social Services of the National Council of Provinces (NCOP) because we are deeply concerned that the current version of the NHI Bill (the Bill) undermines the country's ability to address inequalities in access to affordable healthcare. **We believe that with small but critical changes, which enable both the public and the private sectors to work together, a sustainable and affordable NHI is possible.**

- If passed in its current format, the Bill will cause much harm to the country's overall health care system, to the people that depend on it, to the country's financial position, to the broader economy, and to the sustainability and creation of jobs. The tax increases required to fund the NHI Bill (as estimated by the National Department of Health) are significant and untenable, particularly in the current economic climate.

- It will also have a significant impact on the provinces. While we outline the full extent of this impact in our submission, it is important to highlight that the NHI Bill re-assigns an estimated R196bn (85%) from provincial budgets for health to the National Department of Health and the NHI Fund, through amendments to the National Health Act. This is about 28% of provinces' equitable share on average. It also creates significant human resources restructuring requirements (between the Fund and provinces) for which there is no detail outlined in the Bill or in the associated impact assessments. The centralization of funding requires a planning process that will mitigate any risk of interruptions in service delivery and protect the rights of affected healthcare personnel.

- Importantly, the NHI Bill has several unconstitutional provisions, and the NCOP is mandated to address unconstitutional matters by amending the Bill or referring it back to the National Assembly for revision. These unconstitutional provisions include:
    - The Bill imposes funding obligations on the fiscus, specifically through raising taxes, which should be dealt with in a Money Bill, in accordance with the Constitution;
    - The Bill was irrationally approved by the National Assembly in the absence of a current affordability analysis and without any affordability interrogation;
    - The Bill unnecessarily / excessively infringes citizen's rights to buy private healthcare services and to privately insure for access to healthcare services and the risk of non-delivery by the NHI Fund;
    - The Bill contains internal contradictions about what is amended, what is proposed to be amended, and related timing, to the extent that it is irrationally vague and ambiguous;
    - The Bill unnecessarily / excessively restricts the competition law framework;
    - The Bill unnecessarily / excessively amends the POPIA framework; and
    - In terms of the NHI Bill's approval in the National Assembly:
        - There was inadequate public consultation about the proposed knock-on amendments; and

- The National Assembly irrationally sought "for or against" commentary from public participants without interrogating the substance of their submissions.

- BUSA and B4SA have made constructive technical proposals which will enable the NHI Bill to advance universal health coverage in a sustainable and affordable manner and address the constitutional challenges set out above, for the benefit of everyone in South Africa. These proposals have been ignored in the National Assembly legislative process. They address the following:
  - No rationale has been provided for the addition of the limitation on medical schemes to the 2019 version of the Bill;
  - The definition of 'fully implemented' NHI and an appropriate approach to determining the role of medical schemes;
  - Sustainable phases of implementation including proper consideration of required legislative changes;
  - The process for determination of provider pricing in the interests of healthcare value and sustainable access to care;
  - Consequently, we propose *inter alia* replacing the current version of section 33 with wording along the lines of the following: "*Once National Health Insurance has been <u>fully implemented</u> as determined by the Minister in consultation with the Benefits Advisory Committee and the Stakeholder Advisory Committee, the Minister shall publish notice of such determination in the Gazette, and may make regulations regarding the role of medical schemes consistent with the objective of the progressive realisation of access to sustainable, quality healthcare services by users of the Fund*".

- The NCOP plays an indispensable role in fulfilling its constitutional mandate to the people that it serves, and for this reason, we implore the NCOP to carefully interrogate the viability and unintended consequences that could arise from the current version of the Bill. South Africa's health care system has much to gain if we get this right. It is essential that we do.

- We appreciate the opportunity to make this submission and would welcome the opportunity to present our concerns to the NCOP in person.

2 Introduction and Overview

1. BUSA and B4SA thank the Select Committee on Health and Social Services of the National Council of Provinces ("the Committee") for the opportunity to provide comments on the NHI Bill ("the Bill"). This submission is being made by Business Unity South Africa (BUSA), together with its implementation partner, Business for South Africa (B4SA). BUSA represents organised business in South Africa, and B4SA was formed during the COVID-19 pandemic as an all of business response, spearheaded by the Black Business Council and BUSA. B4SA worked collaboratively with the Government and social partners during the pandemic, including procuring PPE (primarily for the Solidarity Fund), working with social partners at Nedlac to access social relief, and drafting the accelerated economic recovery strategy. In the second year of the pandemic, B4SA focused on collaborating with government and other social partners on the design, development and operationalisation of the vaccination roll out programme, ensuring once again that critical skills were mobilised and partners and funders such as the Solidarity Fund could help enable that critical intervention.

2. BUSA/B4SA and its members support the objectives of the NHI Bill as set out in the Preamble to the Bill insofar as this relates to addressing inequities, social justice and improving quality of life for all citizens. We support the overarching goal of universal access to quality healthcare services (in accordance with Section 27 of the Constitution) for all South Africans. We are mindful that South Africa is one of the most unequal societies in the world and that health financing arrangements therefore must achieve a more equitable redistribution of resources. We recognise that access to affordable healthcare and services is both a requirement for individual and family wellbeing and quality of life, and also a determinant of productive livelihoods, in local communities, places of work and the economy as a whole. Through its extensive membership base, BUSA represents the private sector being the largest federation of business organisations in terms of GDP and employment contribution. As an active private sector representative body, we are supportive of policy changes that will stimulate productivity and economic growth in South Africa.

3. BUSA/B4SA is committed to contributing to the strengthening of the South African health system. BUSA/B4SA and its members agree that there should be universal health insurance coverage. This is a key component for NHI implementation.

4. BUSA/B4SA supports that:

    i. The NHI Fund should be established as a public funder of health services which will facilitate the development of public private partnerships as well as the strengthening of public sector capacity.

    ii. Consistent with UHC principles, quality of care is paramount – whether one seeks care in a publicly or a privately-owned hospital, should not lead to differences in quality or reliability of care.

iii. A primary healthcare gatekeeper approach is appropriate, both for the protection and assurances it represents to users of health services and because it contributes to overall cost controls and avoidance of over-servicing.

5. Our main concern is the feasibility of the single fund approach as set out in the Bill. This means the NHI Fund is positioned as the single purchaser of health services included in the NHI benefit package on a monopsony (single buyer) basis, and thereby controls the entire health market to the exclusion of all other participants or contributors.

6. This single fund approach also means there is a legislated limitation on the role of medical schemes in providing cover, effectively immediately undermining the role of medical schemes and therefore the entire private healthcare system. Our view is that this is not a feasible or sustainable approach to achieving the goal of UHC and that the Bill should provide for an incremental approach in implementation that includes a role for multiple funding sources. These concerns arise from:

    i. A single fund approach that relies entirely on public financing of healthcare for the whole population is not fiscally realistic or sustainable;

    ii. The taxation requirements to fund a comprehensive package of healthcare services are unrealistic and would have severe adverse impacts on South Africans and the economy broadly, and in any event have yet to be appropriately and accurately set out and costed;

    iii. The risks of a single fund approach include accumulating deficits (exacerbating fiscal risk) and limitations on access to healthcare services for vulnerable members of society – this is in line with what other low- and middle-income countries (Indonesia, Taiwan, Ghana and Zambia) have experienced when implementing single fund models[1];

    iv. The single buyer contracting provisions, which eliminate cross subsidies between private and public funders, could destroy the private healthcare market further limiting the opportunity for sustainable access to affordable healthcare for all South Africans;

    v. This raises the risk that the healthcare services will be limited to what public resources are able to cover and citizens will be prevented from accessing any healthcare services outside of those provided by the NHI;

    vi. No other country has implemented a legislative limitation of the role of private health insurance, since this is a critical measure to enable those with the means to purchase their own health protection thereby ensuring that more public resources are spent on those who cannot afford to provide for themselves;

[1] Ghana and Zambia are countries where promised benefits have had to be reduced as a result of deficits.

vii. A single fund approach does not achieve equity since it will result in wealthier users being able to claim disproportionately more from the public resources due to their higher levels of utilisation and easier access to the healthcare services and facilities (all other things being equal);

viii. The uncertainty relating to the extent of the benefit package (which has been referred to in some forums as being based on "essential services" and in other forums as "comprehensive") as well as the associated uncertainty with respect to funding has caused unnecessary distress. amongst stakeholders. As framework legislation, the Bill must therefore reflect that these will be determined on a collaborative and fiscally sound basis.

7. The COVID-19 pandemic demonstrated the dire need for a healthcare system that is resilient to protect society and the economy. This is all the more relevant given the high disease burden prevalent in South Africa. In the second year of the pandemic, B4SA was a partner in the government led programme to combat the effects of COVID-19 and to roll out a vaccine programme to all South Africans. This clearly demonstrated the benefit of sharing resources and expertise on a collaborative basis for the common goal of protecting all South Africans. The COVID-19 vaccine programme was a clear example of a common benefit package with a clear contracting framework whereby vaccines were available to all South Africans at accredited facilities (whether public or private) free at the point of care. The vaccine programme was funded by both government and private sector funding, with the price charged to the private sector incorporating cross subsidies to support greater access. This is a valuable model for implementing healthcare cover on a multi-payer basis and may have implications for NHI.

8. The effect of Section 33 of the Bill is to limit the rights of the private health sector to continue to conduct business after full implementation. This limitation effectively immediately undermines the role of medical schemes and therefore the entire private healthcare system and has a negative impact on the economy as a whole. The legislative provision in the absence of clarity has already led to a loss of confidence in a sustainable operating environment in the private health sector which has dire consequences for access to care in the future. South Africa needs policy certainty to attract investment (in the health system, and generally).

9. The Bill and its Explanatory Memorandum <u>do not</u> demonstrate that the limitation of rights imposed is indeed in the interest of social welfare and that the aforementioned objectives could not have been achieved through alternative models that are more targeted and less invasive. Nor why such limitation was added in the 2019 version of the Bill when it was previously absent. We believe that there are immediate opportunities that can be adopted to improve access to healthcare in South Africa and that these should be urgently considered rather than proceeding with a drawn-out and unfeasible implementation. These opportunities can be implemented alongside the NHI Fund and will result in

i. immediate improvements in access to cover that is offered on a social solidarity basis that will enhance productivity and economic growth for the benefit of all;

ii. enhancement in the accessibility of public facilities due to the alleviation of demand on this sector;

iii. immediate reductions in out-of-pocket expenditure for health services, particularly amongst lower income households;

iv. attracting investment into the private health sector with the attendant contracting opportunities for the NHI Fund;

v. enhancements in access to care for all South Africans through sustainable contracting with private sector facilities to enhance capacity;

vi. a growing pipeline of health professionals to address our declining provider/patient ratios through expanding the available treatment platforms on a soundly regulated basis.

10. We emphasize in our submissions the unintended and detrimental consequences of this restrictive and invasive policy stance. In addition, we are of the view that alternative solutions exist. Most significantly this requires collaboration between public and private sectors as private sector support is necessary for achieving the important objective of improving access to care for all. It is entirely feasible (and will be ultimately optimal), to utilise the resources and capabilities of both the public and private sectors to achieve the goal of equitable access to quality healthcare for all, which is so vital to human dignity and addressing the inequality that presently exists in the healthcare system. The lack of consideration given to alternative approaches to healthcare reform and constructive inputs to the Parliamentary Portfolio Committee process present a clear Constitutional challenge to the progress of the Bill.

11. The South African health care sector is a national asset, in which the private sector can play an important role in a sustainable NHI model that benefits all citizens, regardless of their socio-economic status. The Bill can easily be refined to facilitate this and can incorporate a role for the private sector on a basis that supports the provision of healthcare services to all South Africans. The proposals for funding the NHI Bill through increasing tax revenue do not take cognisance of South Africa's economic constraints nor the limited opportunities to impose more taxes on a diminishing tax base. While no detail of the proposed NHI benefits and no costing of the NHI has been presented (since 2011), the Department of Health has referred to the unrealistic intention of raising R200bn from taxes. This is not only at odds with the role of the Department of Health vis-à-vis National Treasury in terms of setting tax policy, but it has already had disastrous consequences on South Africa's ability to attract investment generally, and in the health sector in particular.

12. There have been adverse consequences on consumer and business confidence with the consequential negative effects. Of particular concern has been the negative impact on the confidence of health professionals regarding their career prospects in the South African health system. This loss of skills (and potential skills through the training pipeline) has dire consequences for access to health services in the future.

13. We have demonstrated that there are alternative models for achieving the stated policy objectives set out in the Bill and hence the legislative limitation on the role of medical schemes is not necessary. Drawing on a range of funding sources on a social solidarity basis is likely to be both less risky and more effective in achieving the policy objectives than a single fund approach. There is therefore a constitutional obligation to implement such an approach rather than proceeding with the limitation of the rights of medical scheme members. This has been confirmed by the report of the Parliamentary Legal Services.

14. Independent of the NHI Bill, the Health Market Inquiry that was initiated by the Minister of Health and conducted by the Competition Commission made important recommendations as to how the inefficiencies in the private health sector which arise from incomplete implementation of the social solidarity regulatory framework can be addressed. After a detailed and thorough assessment and informed by experts, the HMI did not recommend the removal of the role of the private sector but rather recommended that there should be better integration between the public and private health sectors and that regulatory failures are addressed to improve efficiency and value for health care consumers. Implementing these recommendations will have the effect of immediately reducing the cost of medical scheme cover and improving access to cover and we appeal to the Department of Health to act on these which will progress South Africa's UHC score.

15. Our submission includes the following:

i. We commence with an overview of BUSA and B4SA, its members and position in support of universal healthcare coverage (UHC);

ii. We present an analysis of the expected economic impact of the NHI Bill, especially given a weak and fiscally constrained macro-economic environment;

iii. We set out the unintended and detrimental consequences of section 33. There is no clear rationale for section 33 and there are feasible alternative ways of reaching the policy goals, therefore there is no rational basis for this approach being adopted;

iv. We identify key concerns with the Bill including:

a) Section 33 of the Bill is unnecessary for attaining the policy objective of universal health care and introduces significant risk due to the single fund model and the adverse impact on people's ability to seek care in the private sector.
b) The contracting provisions in Sections 11 and 26 of the Bill are unsustainable and inconsistent with the principles of value based care which is the global trend for sustainable healthcare contracting that is patient centred.

c) The phased implementation in Section 57 of the Bill has been linked to the dates rather than to milestones that are relevant to South Africans having reasonable access to quality healthcare services.
d) The legislative changes included in Section 58 of the Bill appear to be immediate in effect which is in conflict with the provisions of Section 31 of the Bill and results, for example, in the immediate removal of health functions from the Provinces which impacts around R196bn of funding which is currently paid to Provinces. No plans for implementing these massive shifts in funding and functions have been published for discussion/consultation and this has ramifications on the rights of employees as well as service delivery.
e) The sources of funding set out in Sections 48 and 49 of the Bill are the remit of National Treasury and should be dealt with in a Money Bill in accordance with the Constitution.
f) There are serious concerns regarding the right of access to health services created by provisions in Sections 7 and 45 of the Bill.
g) There are conflicts with the Competition Act and the Protection of Personal Information Act which need to be addressed in consultation with the Competition Commission and the Information Regulator.

v. We note that there is substantial evidence that shows that a single **public** fund can achieve the same goals by allowing private providers to cross-subsidise their income between the public and private funders. This will ensure the sustainability of the healthcare system as a whole.

16. Key recommendations are:

i. Independently of the NHI Bill, South Africa needs to address inequalities and gaps in the current health care system and deliver a strengthened system that is robust, efficient and above all, sustainable and affordable for users.

ii. The Bill introduces serious systemic risks associated with governance, the country's ability to attract and retain skills and investment, the removal of competition in buying health care services, and the feasibility of raising taxes. These risks can be addressed through:

- More flexible wording for Section 33; and
- Simplification of the NHI Bill to ensure that phased approach has clear implementation pathway taking account of unintended consequences.

iii. The transition to NHI has to be a phased approach and there is a need for more, and in-depth, engagement on the options for NHI design and the sequencing of reform steps. In particular, and separately from NHI, the Health Market Inquiry made detailed recommendations regarding better integration of the public and private health sectors and how regulatory changes can enhance the efficiency and affordability of the private health sector.

iv. Issues of governance of NHI must be addressed to ensure buy-in from all stakeholders.

v. A sustainably structured NHI can dramatically improve healthcare in South Africa. Critical to this is harnessing the deep and valuable experience, resources, capacity, advanced technology, systems and track record that exists within the private health care sector, including hospitals, GPs, specialists, nurses, ambulance services and medical schemes. These world-class resources can be leveraged to support the delivery of a robust and sustainable NHI model that benefits all, and that is affordable for the country.

17. This submission is based on extensive research by experts in the field. We reference the research throughout our submission which was set out in the Annexures to the BUSA submission to the Portfolio Committee on Health on 29 November 2019. The Annexures contain a wealth of research and data which we believe will inform the work of the Committee in considering the impact of the detail of the NHI Bill.

18. BUSA/B4SA would welcome the opportunity to engage further with the Committee on these vital issues.

3 BUSA and B4SA – Role and Position on equal access to healthcare

3.1 Role

19. Business Unity South Africa (BUSA) represents organised business in South Africa and is the formally recognised representative of business at the National Economic Development and Labour Council (NEDLAC). Through its extensive membership base, BUSA represents the private sector, being the largest federation of business organisations in terms of GDP and employment contribution. BUSA serves as a social partner in the national policy development and social dialogue processes. The membership of the BUSA health working group includes entities across healthcare providers, pharmaceuticals, medical devices, hospitals, medical schemes and administrators, insurers and corporate employers.

20. Business for South Africa (B4SA) was formed during the COVID-19 pandemic as an all of business response, spearheaded by the Black Business Council and BUSA. Large or small, informal or formal businesses, across all sectors of the economy, some not members of organized business, brought skills and subject matter expertise to bear, and worked together on an integrated basis to save lives and livelihoods. B4SA worked collaboratively with the Government and social partners during the pandemic, including on the procurement of PPE (primarily for the Solidarity Fund), working with social partners at Nedlac to access social relief, and drafting the accelerated economic recovery strategy. In the second year of the pandemic, B4SA focused on collaborating with government and other social partners on the design, development and operationalisation of the vaccination roll out programme, ensuring once again that critical skills were mobilised and partners and funders such as the Solidarity Fund could help enable that critical intervention. B4SA's objective is to mobilise business resources and capacity to work alongside and in support of government to address bottlenecks impacting economic growth and social development in South Africa. B4SA is the implementation partner of BUSA, and is able to mobilise business broadly to support government in focused initiatives that, when implemented, will result in increased investment and economic growth. B4SA is enabled to work in a flexible way with quick decision-making and resource mobilisation.

21. BUSA and B4SA have established a Health Policy Project which brings together business organisations from the health sector and the broader economy to co-ordinate inputs on health policy for the benefit of all South Africans. There is a willingness amongst participants from across the private sector to provide constructive support to strengthening the South African health system and improving access, quality and affordability. Illustrative of this willingness and commitment, is BUSA's participation in the Presidential Health Summit (2018 and 2023) and the development of the Health Compact signed in July 2019. These are system strengthening initiatives that cover a broad spectrum of issues which we support.

22. During the COVID-19 pandemic which severely impacted the health sector and the economy more broadly since 2020, there was constructive collaboration in the emergency response and in the procurement, funding and roll out of the vaccination programme. These were government led and co-ordinated initiatives that rapidly brought together the resources and skills to support an effective crisis response.

23. COVID-19 demonstrated how the health system is inextricably linked to the social and economic well-being of South Africans and that the collaboration of government with the private sector was critical for a rapid and effective response. The COVID-19 pandemic demonstrated the dire need for a healthcare system that is resilient to protect society and the economy. This is all the more relevant given the disease burden prevalent in South Africa.

24. Amongst other initiatives, B4SA was a partner in the government led programme to combat the effects of COVID-19 and to roll out a vaccine programme to all South Africans. This clearly demonstrated the benefit of sharing resources and expertise on a collaborative basis for the common goal of protecting all South Africans. The COVID-19 vaccine programme was a clear example of a common benefit package with a clear contracting framework whereby vaccines were available to all South Africans at accredited facilities (whether public or private) free at the point of care. The funding was based on both public and private funding sources with private sector cross-subsidisation which promoted greater access for the population as a whole. This is a valuable model for implementing care on a multi-payer basis.

25. In providing comments on the NHI Bill to the Committee, we need to emphasise that there is a need for more, in-depth engagement on the options for NHI design and the sequencing of reform steps. We have a particular concern about the implications of the Bill for medical schemes, in part because they represent a substantial flow of funds to health service provision, but also because they bring a substantial administrative capacity to the health system which is, as yet, far from fully utilised, and should be mobilised in support of the implementation of NHI.

26. In the policy processes to date, the underlying understanding has been that the private health sector and medical schemes, though subject to reform and regulatory change, would remain integral parts of the heath system under NHI. The Health Market Inquiry (HMI) that was established by the Competition Commission and conducted its work over the period 2012 to 2019 made important recommendations as to how the inefficiencies in the private health sector which arise from incomplete implementation of the social solidarity regulatory framework can be addressed. After a detailed and thorough assessment and informed by experts, the HMI did not recommend that removal of the role of the private sector but rather recommended that there should be better integration between the public and private health sectors and that regulatory failures are addressed to improve efficiency and value for health care consumers.

27. Section 33 of the NHI Bill undermines this supportive and collaborative role. It creates the expectation that medical schemes (and by implication private health services), will at some time in the future no longer be available to South Africans except for a range of as yet unspecified services that fall outside of the ambit of the NHI's coverage. This represents a complete reversal of prescribed minimum benefits and community rating that underpins our medical schemes environment.

28. A reversal in policy of this kind, and the extent of regulatory restriction on private health insurance and hence on access and coverage for private healthcare services is historically and internationally unprecedented. It is entirely unclear how the transition in regulation of medical schemes and private health services is to be managed. The resulting uncertainty will undermine investment, systems development and expansions in service delivery in both healthcare and health insurance, while offering no discernible benefits or advantages to anyone.

3.2 BUSA/B4SA Position: Strengthening the South African Healthcare sector.

29. Our primary point of departure is that South Africa's health service delivery capacity, in both its private and public sector components, is a national asset on which the well-being of all South Africans depends. In adopting an NHI framework to ensure that this capacity meets all South Africans healthcare needs equitably, we have a historically unique opportunity to ensure that the strengths, capabilities, resources and expertise of both the public and private sectors are fully, effectively and efficiently mobilised.

30. In adopting NHI for the future evolution of our health system, there is an opportunity to address the underlying causes unequal access to services, and to do so within a framework that encompasses both public and private service delivery and financing arrangements. The Health Market Inquiry (HMI) identified a number of opportunities for enhancing efficiency in the private sector and better integration with the public sector.

31. Many of the efficiency challenges in the delivery of care in the private sector are due to regulatory shortcomings as confirmed by the HMI and the private sector is committed to addressing them in co-operation with government in the public interest., In contrast, the challenges in the public sector relate to the actual delivery of health services as well as the lack of equipment and infrastructure to deliver care. It would be highly regressive to restrict the ability of the private sector to deliver health care before there is significant improvement in the quality and accessibility of health services available in the public sector since shifting more lives into relying on public resources will only exacerbate the current challenges. It is our view that a process of effective collaboration is required as both categories of challenges need to be addressed to build an integrated and affordable health system that is effective in delivering care.

32. We propose revisions to the NHI Bill that would have the effect of widening the scope for cooperation across the public and private sectors and would ensure that we take advantage of the strengths and capacity of the entire health sector, including the medical schemes industry, in advancing towards universal and comprehensive coverage.

33. Section 33, which envisages a narrowly restricted "complementary" role for medical schemes once NHI is fully implemented, will inhibit medical scheme's role in adapting and piloting health benefit design and management arrangements aligned to the intended universal health coverage model. This is self-defeating since:

    i. It will not improve quality access for all; and

    ii. It is not supportive of the goals of the NHI.

34. It would be better to build a contracting framework that is scientifically informed, independent and transparent consistent with sustainable access to affordable quality care. This will support contracting subject to agreed standards and quality assurance procedures. This approach has enabled countries like Germany and the Netherlands to progress from private sector or employer-based health insurance systems to towards cost-effective and efficient universal coverage. This is particularly the case for other middle-income countries such as Chile, Thailand, China and Brazil[2].

35. There is no rationale for the severe restriction of the private sector implicit in section 33 has been set out in any policy document to date. No evidence has been provided that the proposed limitation will advance the achievement of universal health coverage, reduce the burden on the fiscus or widen the scope of healthcare benefits available to South Africans. It is hard to reconcile this intent with the most recent proposed amendments to the Medical Schemes Act (2018), which clearly envisages a continuing significant role of medical schemes in financing prescribed benefits and of private service providers in delivering healthcare. The final report of the HMI (September 2019) also recommends specific policy measures that would strengthen the functioning of the private healthcare sector.

36. Most South Africans are mainly dependent on health services financed through the national budget. In these circumstances of severe fiscal constraints, universal health coverage fully financed through budgetary resources is unrealistic. In our view, more rapid progress in improving quality and strengthening access to health services could be achieved if reliance on the budget was complemented by expanded membership, on affordable terms, of medical schemes that meet the mandatory health service benefits of the NHI. The NHI Bill, in effect, foregoes this opportunity, in favour of a single integrated NHI Fund rather than mandatory standard coverage for all. We expand on these issues below.

[2] Refer to the Insight Report for more detail. INSIGHT ACTUARIES (2019). "A Transitional Framework for achieving Universal Health Coverage in South Africa". A research report for Business Unity South Africa.

4 Expected Economic Impact of the NHI Bill

37. In this section we set out the current framework for healthcare financing in South Africa and how the proposals contained in the NHI Bill affect this. We also consider the impact that the NHI Bill is likely to have on the economy, given the ambitious roll-out timeframe in a very weak fiscal environment.

4.1 Background to healthcare financing in South Africa

38. Healthcare services in South Africa are currently primarily financed from the following sources:

- Public funding from tax revenue which is primarily allocated to provinces through their equitable share, as conditional grants, funding allocations to other spheres of government;

- Medical scheme contributions which are paid by individuals and/or their employers. Taxpayers who belong to a registered medical scheme are able to claim a tax credit which reduces the total tax they need to pay to SARS. Medical schemes are not-for-profit entities, and their reserves are private fund assets which belong to the medical scheme members; and

- Out of pocket expenditure by individuals who purchase healthcare services in the private sector which are not covered by any other form of insurance. Around 40% of South African households are spending some money on an OOP basis on healthcare services which are funded from after tax revenue.

i. Health insurance products that are regulated under insurance legislation and operate on a for-profit basis.

ii. Other sources which are less significant contributors include donor funding, statutory insurance entities such as the Compensation Fund and Road Accident Fund and employers.

Table 1: Estimates of health financing sources 2023

Health expenditures	Rbn	Source
Consolidated health budget 2023/24	259	National Treasury
Medical scheme gross contributions 2023	230	CMS report inflation adjusted
Out of pocket expenditure	40	Estimate
Statutory and other insurances	10	Estimate
Total	**539**	

39. Medical scheme tax credits are amounts that taxpayers are able to deduct from their personal income tax payable as a result of having medical scheme coverage. The medical scheme tax credits for 2023/4 are R364 for the first two beneficiaries and R246 per beneficiary thereafter. For example, a medical scheme member with 2 dependants will be able to deduct R974 (R364 + R364 + R246) from their monthly tax payable each month (R11 688 for the year). Removing the medical scheme tax credits would mean that medical scheme members will pay more tax. It does not affect the revenue of medical schemes as is erroneously stated in Section 49 of the NHI Bill.

40. Provincial allocations: The roles and functions of the national and provincial governments in respect of health services are set out in the National Health Act. The Constitution authorizes both national and provincial governments to enact legislation with respect to health services and the NHI Bill includes amendments to the National Health Act which move functions from the Provinces to the National Department of Health, the NHI Fund and the District Health Management Offices (which are yet to be established and will fall under the National Department of Health). The effect of these changes in functions is that approximately 85% of the provincial health allocations will be redirected and no longer paid to provinces. This has significant implications for service delivery and for conditions of employment for provincial health employees. No planning for these changes has been presented nor was any reference made to these significant changes in the SEIAS documents publishes with the NHI Bill.

41. International comparisons: In 2001, African Union countries set a target of allocating at least 15% of their budget each year to the health sector, known as the Abuja Declaration. As recently as February 2023, African leaders recommitted to implementing the Abuja Declaration Target. In 2020, only South Africa met the target.

4.2 Financing Issues in a fiscally constrained environment

42. The NHI Bill does not include any estimate of the costs of the NHI or how it will be financed. While we recognise that the Bill is creating the funding framework, BUSA/B4SA is concerned that such a large-scale fiscal project is being rolled out in a very weak macro-economic environment. In this regard we note that the general guidelines for Socio Economic Impact Assessments (SEIA) in SA specifically highlight the NHI as an example of a policy change which: “will require a large research programme and ideally some modelling of the economic and social impacts”[3]. This has not been done in the previous Initial Impact Assessment of the NHI Fund[4], and neither has it been done in the latest version of the SEIA.

[3] SEIA Framework Document, Department of Planning, Monitoring and Evaluation

[4] Department of Planning, Monitoring & Evaluation, SEIA (July 2017). Initial Impact Assessment: NHI Fund.

43. In fact, we note in the NHI 2019 SEIA, National Treasury explicitly objected to the single-payer model. The SEIA 2019 reports the benefits, costs and risks associated with the NHI Bill considered by affected stakeholders. It is reported that National Treasury noted concerns relating to the impact of the cost of NHI on tax-payers, as well as the risks associated with the fiscal space and sustainability. As a result, while National Treasury indicated conditional support for a limited benefit package under NHI, they want to retain a multi-payer environment for healthcare.[5] The fact that this submission is not in the public domain, and the only reference to this is included in the SEIA, is problematic. This restricts the ability of stakeholders to provide constructive input and comments on the phased roll out of the NHI.

44. BUSA/B4SA is of the view that the NHI Bill cannot be passed without an accompanying publication by National Treasury on the cost and financing options for the NHI proposals. The problem is that, while the Bill does not contain any cost estimates, it does refer under point 8 of the Memorandum to work that was commissioned by Treasury which provides estimates of costs of "a set of 15 or so interventions". It is then stated that: "The full set of interventions costs in the longer term around R30 billion per annum"[6]. However, the Department of Health has made presentations to the Portfolio Committee on Health which refer to raising taxes of R200bn per annum. BUSA/B4SA request that the report on these financing options is released for public input and suggests that moving the Bill forward without this is inappropriate. Section 49 of the Bill is also inappropriate and inaccurate and should be removed.

45. Consistent with WHO guidelines for governments to progress towards UHC through scenario planning and a primary healthcare (PHC) focus, FTI Consulting[7] has calculated the costs of providing different baskets of care, PHC under a capitation model, maternity care, emergency care, as well as prescribed minimum benefits (PMBs)[8]. These estimates provide a sense of the cost of providing basic packages of care to the entire population, both insured and uninsured. The analysis relies on data from the Council for Medical Schemes (CMS) on expenditure by medical schemes various packages of care, with a range of efficiency and utilisation assumptions and applied to the whole population.

---

[5] SEIA 2019. p 19.
[6] NHI Bill, 2019, p. 57.
[7] See BUSA Submission 2019 Annexure FTI Note 1. Healthcare provision under NHI: considerations under section 33
[8] See BUSA Submission 2019 Annexure FTI Note 1. Healthcare provision under NHI: considerations under section 33

46. These estimates are likely to be lower bound estimates of the true cost of care, as they are based on 2018 values. Nonetheless, they provide a range of estimates of the cost of cover for the entire population. The modelling also includes assumptions around increased efficiencies, discounted services by GPs and savings that could result from improvements to the system. Taking such savings into account, it is estimated that the cost to the NHI Fund of contracting private sector practitioners to provide healthcare services to the entire population (or public sector resource building to provide services on the basis of reasonable access levels) – including the insured population due to severely restricting the role of medical schemes (Section 33) – will be substantial. This would therefore be detrimental to the levels of UHC.

47. The summary findings are presented below.

Table 2: Summary of additional costs of providing healthcare under NHI and section 33

	Lower bound estimate	**Upper bound estimate**
Primary Healthcare (PHC) (excluding medication)	R 82.70bn 8 hours, 15 min consultations 50% GP salary cut Public sector lower bound utilisation	R 150.14bn 7 hours, 20 min consultations Full GP salary OECD average utilisation
Maternity care + medication	R 183.89bn 50% efficiency discount 50% GP salary cut Public sector lower bound utilisation	R 333.09bn No efficiency discount Full GP salary OECD average utilisation
Prescribed Minimum Benefits (PMBs)	R 323.20bn 45% efficiency discount	R 587.71bn Current private rates
Emergency care	R 3.83bn 50% efficiency discount	R 7.56 bn No efficiency discount

Source: FTI Consulting[9]

[9] See BUSA Submission 2019 Annexure FTI Note 1. Healthcare provision under NHI: considerations under section 33

48. While these calculations rely on estimates of expenditure from before the COVID-19 pandemic, they indicate the quantum of the cost associated with extending cover to the insured market, and the cost of care from private sector providers under various assumptions. Importantly, these costs are in 2017/18 terms. It is therefore clear that the financing costs will be much larger than currently alluded to in the Bill. There are further complicating factors which one should also take note of, such as the fact that the average age of the uninsured population is lower than that of the insured population. Since there are currently no late joiner penalties, medical schemes face anti-selection and this results in a medical scheme population that is older on average than the uninsured population. The private sector is currently set up to treat these patients and including them into the NHI risk pool will therefore increase the overall disease burden on the NHI, and will also put pressure on the cost of delivery.

49. Related to this is the fact that the NHI benefit package has also not been defined. We have seen references to a comprehensive set of services in the past, which as we have shown in this section, is misleading. Populist promises around unlimited free services to all will only contribute to an unstable political environment and unmet expectations. It is the view of BUSA/B4SA that there is an urgent need for a clear definition of the services that will be offered and that could be introduced incrementally as experience and affordability progress. Lack of proper planning in this regard will likely introduce a significant risk of worsening inequality through major variations in levels of cover and access across different areas of South Africa.

50. In 2022, the Department of Health (DoH) published estimates of the revenue requirements for the NHI Fund.[10] The DoH identified R 200 billion in revenue that must be raised via the taxation system, which is revenue "redirected" from private expenditure on medical scheme membership. In the macroeconomic climate in which South Africa finds itself, as set out below, raising an additional R 200 billion via the taxation system will be highly challenging. Indeed, R 200 billion amounts to 12.8% of gross tax revenue, or slightly more than half of VAT revenue.

51. Raising taxes requires a Money Bill which is the domain of National Treasury, who will take into account the fiscal constraints, including the pressure for other social security projects. Various taxation options are available to raise this revenue:

i. **Value added tax (VAT):** Collecting R200bn from VAT would require an **increase in VAT from 15% to 21.5%**. This would have massive ramifications for the poor and for the economy as was demonstrated in 2018 for a 1% change.

[10] Department of Health (DoH). (2022). National Health Insurance (NHI): Key Updates. Policy Dialogue on Universal health Coverage in South Africa. *Universal Health Coverage DAY: "Build the World We Want: A Healthy Future for All."* Slide 13.

ii. **Personal Income Tax (PIT):** Collecting R200bn from PIT means that PIT tax rates would need to increase by 31% across the board. This does not account for the fact that such a large increase in tax payments will result in reduced spending, which will reduce companies' income, and ultimately lead to job losses, which in turn will lower the PIT collected. This impact may only become apparent after one or two years, but the knock-on effects will be significant.

iii. **Payroll tax**: The amount set for a payroll tax will depend on the number of people expected to contribute to the tax. If all the employed (both formal and informal sector) contribute, then the tax amounts to around R1,072 per month per person. If only **those employed in the formal, non-agricultural sector contribute, it is around R1,565 p/m.**[11] This is a significant difference. In addition, it is about ten times the revenue collected via UIF contributions.

iv. **Combination of taxes:** the combination of taxes necessary to raise R 200 billion in revenue is substantial. The combination necessary would involve a 2% increase in VAT, PLUS a 10% increase in PIT, PLUS a 10% increase in corporate income tax (CIT) PLUS a payroll tax levied at twice the rate of current UIF contributions.

52. None of these taxation options are feasible in South Africa, and we may be approaching a point at which increases in the tax rates further diminish the dwindling tax base. With South Africa's tax base comprising just 9% of the population, the tax burden is high and rising as unemployment remains stubbornly high. The expectation that R 200 billion will be raised via the tax base is unrealistic.

4.3 Impact on provincial allocations

53. Section 32 of the Bill provides for the Minister of Health to determine what role the provinces will play in delivering health care and this must be set out in legislation. The NHI Bill also includes amendments to the National Health Act which result in most functions being shifted from the provinces to the National Department of Health, the NHI Fund, District Health Management Offices and Contracting Units (CUPS) (which will all fall under the National Department of Health directly or indirectly). It appears that the Provincial Departments of Health will be left with only a few functions such as emergency services and disaster management and therefore their funding allocations will be reduced. It is not clear how accruals will be addressed as funds will be reallocated.

54. The Bill is also proposing to decentralise management and control of hospitals where provincial health departments will no longer control and manage the cost and financing of the health facilities, as funding will be paid directly to the hospitals. The financial impact of the proposed changes in provincial functions is that the provincial equitable shares (PES) allocations will reduce significantly since the health budget comprises of a sizeable portion of PES allocations.

[11] Calculated based on the StatsSA QLFS employment numbers averaged for the period 2022q2 to 2023q1.

55. Section 32 of the Bill provides that the Minister may propose amendments to the NHA for centralising funding, however Section 58 of the Bill already makes these amendments to the NHA which will have the effect of removing the functions (and funding) from the provinces. With the amendment of the National Health Act, the district health management offices (DHMOs) will become the primary management authorities, with extensive responsibilities and "considerable powers to manage, facilitate, support and coordinate the provision of primary health care services for personal health care services and non-personal health services at the district level in compliance with national policy guidelines and relevant law".

56. The Bill also provides for the establishment of contracting units for primary health care (CUPs), with which the NHI Fund contracts for the provision of primary health care services within a specified geographical area. The Bill amends the powers and functions of district health councils.

57. The proposed amendments of the National Health Act will have an impact on provincial functions and changing the health functions of a provincial head is a substantive matter which should not be delegated to the Minister to determine through regulations. Similarly, the District Health Management Office and the Contracting Units for Primary Health Care Services are integral structures in the NHI Fund. These functions and powers are substantive matters and should be determined in primary legislation and not delegated to the Minister.

58. Reductions in the PES in the order of **R196bn (a reduction of on average 28% of provincial equitable shares)** in aggregate will have severe ramifications for the employees of provincial health departments and could affect service delivery. A clear impact assessment and robust planning process is required before this is put in place. Our view is that the Schedule in the Bill should only serve as an indication of proposed future amendments that will still need to be "initiated" as normal legislative amendment processes which will require full public participation. We believe that to give effect to Section 32 of the Bill, there should be future parliamentary processes as and when different amendments are to be initiated.

4.4 Economic impact and the consequences of policy uncertainty

59. The South African economy is severely constrained by low economic growth rates. While economic growth reached 2.5% in 2022, this was off an extremely low base following the COVID-19 pandemic in the country. In 2020, GDP contracted 6.3%, and despite growth, albeit off a severely low base, of 4.9% in 2021, and 2.5% in 2022, forecasted GDP growth has been revised downward to just 0.9% in 2023 by National Treasury.[12] GDP growth is projected to remain stagnant at 1.5% and 1.8% in 2024 and 2025, respectively.

[12] 2023 Budget Review. 22 February 2023, p. 2

60. South Africa's fragile growth is impacted most immediately by higher-than-expected levels of load-shedding. Underinvestment in and disruptions to the logistics networks and elevated inflation place significant pressure on household spending, and therefore on economic growth.[13]

61. It is also within this low growth environment that the economic impact of section 33 has to be considered. Given the constraints the State faces in terms of delivering quality healthcare to all, severely restricting the role of medical schemes (and the private sector) is ill advised. Section 33, if implemented as drafted in the NHI Bill, will negatively impact on the private healthcare sector, investor confidence and ultimately the wider economy. It will do this through the impact on investor sentiment, but also through direct negative impacts on a large number of healthcare businesses which are major tax payers and employers. In addition, the impact will not only be on large firms, but it will also negatively impact on current initiatives to transform the healthcare sector by facilitating entry for SMME's and firms owned by historically disadvantaged persons.

62. In an economic environment characterised by waning investor confidence and a diminishing tax base, South Africa needs to attract investment to the country in order to stimulate economic growth and shore waning investor sentiment. With unpredictability and instability in power supply plaguing business operations in the country, investors desperately need confidence that other elements of the macroeconomic environment are stable and supportive of establishing long term assets in the country. A healthcare system providing high quality services is a major consideration for potential investors, and the perception that the continued functioning of such a system is under threat poses a very real risk to investment sentiment. Any changes perceived to have an adverse impact on consumer and business confidence may have a significant negative impact on SA investor sentiment. Aside from the direct negative impacts on the private healthcare system outlined above, if Section 33 remains in the NHI Bill, it will further erode investor sentiment for the following reasons:

63. **Uncoordinated policy processes**: The dramatic intervention in the private health insurance market as envisaged in Section 33, is contrary to other policy processes such as those reflected in the Medical Scheme Amendment Bill and the HMI report. This type of policy uncertainty is perceived as a big risk by investors. There is also a lack of co-ordination with other reform processes that may have fiscal impacts such as relating to the National Savings Fund, the Basic Income Grant and the need for reform in the provision of basic education. Co-ordination of these reform processes is essential to ensuring that the overall fiscal approach remains feasible.

[13] 2023 Budget Review. 22 February 2023, p. 13

64. **Lack of adequate healthcare infrastructure and insurance for business employees**: Investors, whether local or foreign, take careful note of the environment in which their employees live and work. A key consideration here is access to good quality healthcare and health insurance. Given the track record of the public healthcare system, and the financial constraints outlined above, it is very unlikely that the NHI will be able to provide access for the whole population to the quality and breadth of services that are currently accessed by the 9 million medical scheme members. In this situation, the impact of Section 33 will mean that business leaders will not be able to ensure that their employees have access to health insurance and private healthcare, even if they can afford to provide this. This will itself prevent new foreign investment in South Africa, and will also reduce investment by local businesses.

65. **The need to address inequality in healthcare access in South Africa**: Social development and stability are key considerations for private sector investors as these factors relate to a stable and productive operating environment and the overall economic well-being of the society in which they operate. The willingness of South African corporates to support public health interventions during the COVID-19 crisis clearly demonstrates the commitment to contributing beyond the ambit of the private sector and the recognition that the health of the nation has broad social and economic consequences.

5 The effect of section 33 is counter-productive to the goal of UHC

5.1 Background on the current healthcare financing environment

66. The proposed limitation of the role of medical schemes in Section 33 of the Bill appears to have been based on a number of misperceptions regarding medical schemes and how they currently operate. Some clarifying background points are as follows:

    i. Medical schemes are not for profit entities that operate under a social solidarity regulatory framework. This is different to voluntary health insurance in other countries which may operate on a for-profit basis. South African medical schemes are already operating on a basis of pooling funds for healthcare services on the basis of cross subsidies from the healthy to the sick and from high income earners to low-income earners. Medical schemes are therefore ideally suited to operate on an integrated basis with the NHI Fund which will mean a more rapid and less catastrophic trajectory towards UHC.

    ii. Medical scheme members do not run out of benefits as all medical schemes benefit options are required to cover a comprehensive package of prescribed minimum benefits (PMBs) without limits or co-payments. Medical scheme members may be required to use referral pathways for accessing these benefits in the same way as proposed for in the NHI Fund.

    iii. The demographic profile of medical schemes reflects the working population of South Africa and the majority of medical scheme members are Black. Over 50% of medical scheme beneficiaries are from households earning less than R30 000 per month.

    iv. Medical scheme members do not face catastrophic out of pocket payments. For example research published by the Council for Medical Schemes demonstrates that the coverage for cancer treatment for medical scheme members is 96% to 98%. Medical scheme members tend to face out of pocket payments for discretionary items which are highly unlikely to fall within the NHI benefit package – such as advanced dentistry and allied health services.

    v. Medical scheme tax credits are not paid to medical schemes as is erroneously stated in Section 49 of the Bill but reduce the tax payable by medical scheme members. The tax credits are significant for lower income members who could increase the demand on public sector facilities if they are unable to afford to stay on medical scheme cover.

vi. The cost of healthcare services in the private sector is globally competitive however the cost of medical scheme cover has been increasing in excess of inflation. A key contributor to this is the incomplete regulatory framework. Implementing the regulatory recommendations of the Health Market Inquiry would significantly reduce the cost of medical scheme cover and yet the Department of Health has failed to act on these.

67. The HMI recommendations confirm that the failure to complete the social solidarity framework for medical schemes is a driver of costs. which identified a variety of government failures within the private sector supported by the recent publications by the Health Ombudsman about the state of public health services.

68. The consequences of limiting the role of medical schemes do not appear to have been properly assessed. This is a key requirement for a rational approach to health reform as well as for the Bill to be constitutionally sound.

5.2 No clear rationale for section 33

69. The role of medical schemes as reflected in Section 33 of the Bill was not included in the June 2018 version of the NHI Bill and there has been no clear rationale provided for the addition of section 33 to the 2019 version of the Bill. We are concerned that these changes have been based on incorrect assumptions about the population insured by medical schemes. An example of this is the notion that medical schemes cater predominantly to the white population of the country[14]. This is incorrect, as clearly indicated by data from Statistics SA (2021) show that 35.4% of medical scheme members are white, with the majority being African/Black (47.1%), Coloured (10.7%) and Indian/Asian (6.8%).

70. Limiting the role of medical schemes will not automatically lead to current medical scheme contributions being redirected to funding NHI. Medical scheme contributions are paid by members from their (predominantly) after tax income. The only mechanism for funding NHI is by raising taxes and this needs to be considered in the broader economic context as noted above, and also noting that public health expenditure is already at levels in excess of those set out in the Abuja declaration or recommended by the WHO for UHC funding. This suggests that the required focus is more efficient use of resources.

[14] https://businesstech.co.za/news/finance/336171/special-advisor-to-the-president-answers-6-burning-questions-about-the-new-nhi-in-south-africa/Dr Olive Shisana, Social Policy Special advisor to the President of RSA : “For example, 76% of medical scheme members are White, and only 10% are black Africans. Now if medical schemes are allowed to offer the same services as NHI, most of the specialists, doctors, dentists, and allied health professionals will simply provide care to the mostly White people and leave black African people with under resourced providers. This maldistribution of human resources is at the root of the health care crisis”.

71. Medical schemes are obliged by regulations to cover prescribed minimum benefits, which provides extensive catastrophic risk financial protection and protect members from out-of-pocket expenditure. International comparisons indicate that the levels of out-of-pocket expenditure in South Africa are amongst the lowest in the world (WHO Global Health Expenditure Database) and are much lower than other BRICS countries.

72. The HMI highlighted regulatory reform measures that could materially reduce the cost of medical scheme cover and yet these have not been implemented. These include the establishment of a Risk Adjustment Mechanism (RAM) and the introduction of a base benefit package common to all medical schemes. Shortcomings in the existing social solidarity framework for the medical scheme system should be addressed in this way, rather than through its destruction as a system of health insurance and catastrophic expenditure protection. The implementation of the HMI recommendations along with the establishment of the NHI Fund will result in a more rapid and feasible expansion of access to healthcare than the proposed single fund approach.

73. Limiting the role of medical schemes will not result in an improved distribution of health professional resources or lower costs in the private healthcare system, or reduced inequality in access to quality healthcare. Our assessment, set out in our detailed research submissions, is that one of the unintended consequences of section 33 will be to exacerbate the human resource (and other) constraints in the healthcare sector, increase the burden on public health facilities, further narrow access to independent health service providers and reduce the overall envelope of resources available to the health system. Percept[15] identifies a large proportion of unfilled posts in the public sector – 13.8% of total posts. In some instances, vacant posts reported by provinces exclude frozen posts where the DoH has stopped funding a post due to resource constraints. Frozen posts are not reported in Human Resource budgets which means that in many cases, vacant posts understate the shortage of human resources relative to healthcare need. It is incorrect to assume therefore that a reallocation of resources from the private sector to the public sector will ameliorate the deficit of resources in the public sector, or that inequalities arise due to a 'hoarding' of resources in the private sector. Frozen posts are an important driver of public sector resource shortages.

74. We also note that there are no international precedents for so drastically limiting the role of private insurance by regulation that we are aware of. In other jurisdictions with established regulated voluntary health insurance systems, these have evolved or have been incorporated, over time, into the universal cover architecture. This transition path offers both healthcare providers and members the assurance of continuity while providing for reform, improvements in services and expanded coverage along an orderly and sustainable path.

[15] Percept (2019). Human Resources for Health: Key perspectives on supply and absorption.

5.3 No evidence to indicate that a single-purchaser model is the best for South Africa.

75. The introduction of Section 33, which limits the role of medical schemes to reimbursing providers for 'complementary' services, seems intended to ensure that the NHI Fund becomes the single buyer of healthcare services. For the majority of the NHI services basket, the Fund will be able to set the price for both services and products. However, the unintended consequence of this will be to reduce the supply of healthcare providers (and potentially products), as explained above. This means that the overall purpose of an "equitable and fair distribution and use of health care services" will in fact not be achieved.

76. Research done by Insight Actuaries[16] on different healthcare systems, found the following when considering other evidence from low- and middle-income countries (LMICs). There are no LMICs that have successfully implemented a single-payer healthcare model that provides comprehensive coverage for the whole population. UHC does not imply government-only health care, as many countries implementing a universal health coverage plan continue to have both public and private insurance and medical providers. This demonstrates that UHC is attainable in a multi-payer system if it is configured correctly. It is also critical to note that all of the countries reviewed in the Insight study allow private insurers to offer cover in parallel to the publicly sponsored health financing arrangements, and none of these have attempted to make such cover illegal (own emphasis). The detailed work of Insight was included as an Annexure to the November 2019 submission.

5.4 Unintended consequences of section 33

5.4.1 Consequences of the tax proposals on the disposable income of consumers, particularly lower income earners.

77. In Section 4.2 we detailed the significant fiscal implications of raising the R 200 billion identified by the DoH as necessary to fund NHI as a single-payer system. We have noted the small and diminishing size of South Africa's tax base, and presented estimates of the tax rates necessary across a range of taxes to raise this revenue requirement.

[16]INSIGHT ACTUARIES (2019). "A Transitional Framework for achieving Universal Health Coverage in South Africa". A research report for Business Unity South Africa.

78. While an increase in taxation hampers economic growth in an economy which is struggling, it is important to consider the wider implication of increases in taxation for households who fall below the income tax threshold. According to the General Household Survey of 2021 (GHS 2021) approximately 60% of people live in households with an income of less than R 100,000 per annum, or less than R 70,000 per annum (in the case of households consisting of one person only). While this group fall below the income tax threshold,[17] they are still subject to the payment of VAT and any increase in indirect taxation (such as VAT) will have a significant impact on this group. From a social perspective, this places considerable pressure both on these household members and on the fiscus which provide social benefits for people in this part of the population. This is an important unintended consequence of implementing a policy which relies on such substantial increases in tax revenue, and may have considerable consequence for members of households residing on or near the poverty line in South Africa.

5.4.2 Adverse consequences on the supply of healthcare professionals

79. South Africa faces large challenges in delivering quality healthcare to all, and key to a successful system is a sufficient supply of well qualified doctors, specialists and other healthcare providers. In the detailed submissions contained in the Annexures to the 2019 submission, we show that one of notable unintended consequences of section 33 will be a significant change in the remuneration and workload of medical practitioners and other health professionals in the private sector, which may cause them to reconsider their position as health professionals in SA[18]. Work done by Percept[19] (and included in the Annexures to the 2019 submission) confirms that South Africa currently has a deficit of doctors.

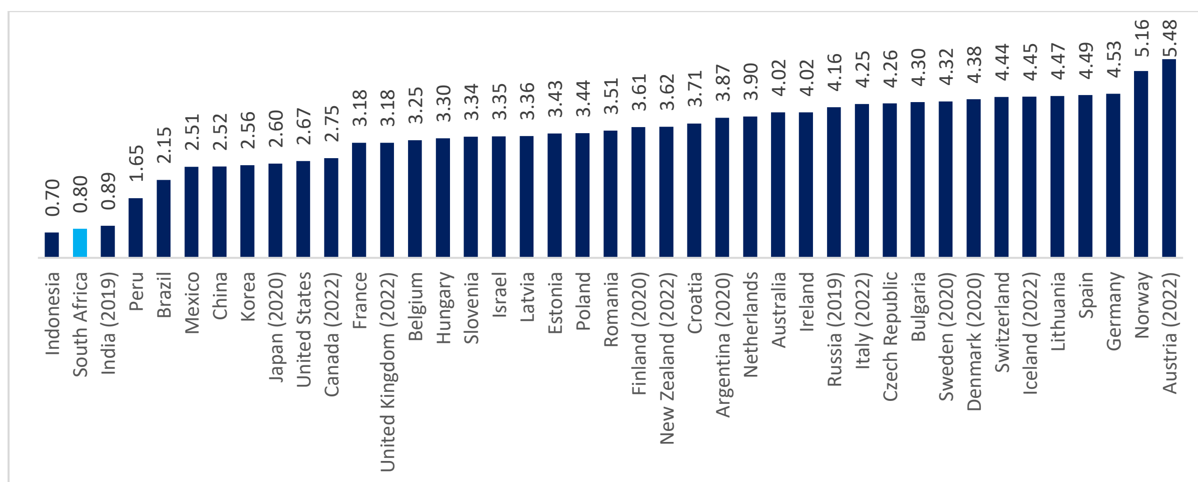
80. The intention of section 33 is to ensure that the NHI Fund becomes the single buyer of healthcare services in South Africa. The Fund will therefore be a price maker, as it can set the price at which services and goods are sold. This introduces the risk that the Fund may set prices too low and the (already low) supply of healthcare providers and products in South Africa will decrease, in the face of increased demand. This is a particular risk associated with the monopsony purchaser model.

81. Funding and pricing healthcare services in the context of rising demand (as a result of, for example, population ageing, the increasing burden of disease, and treatment innovation) and shifting supply side structures is an inherently difficult task, which all countries around the world struggle to do successfully. BUSA/B4SAtherefore advocates for a collaborative approach in addressing these challenges.

[17] Set at R83,100 per annum for individuals under the age of 65, for the tax year 2020/21.
[18] FTI Note 2: The Benefits of differential pricing between public and private sectors.
[19] Percept (2019). Human Resources for Health: Key perspectives on supply and absorption.

82. Setting prices for healthcare services on a sustainable basis is a very complex task requiring scientifically informed, independent and a transparent process. In order to illustrate the risks of getting this wrong, the question needs to be asked how the income of healthcare practitioners will be affected if they can only sell their services to the public sector upon full implementation of the NHI. South Africa currently has severe shortages of all classes of healthcare personnel, as shown in the graph below.

Figure 1: Practising physicians per 1,000 population, 2021 (unless stated otherwise))



Source: OECD

83. The Percept[20] study shows that in SA the calculated population ratios of providers across different types are well below OECD averages, and also below comparator countries (Chile, Mexico, Turkey), with the exception of nurses and physiotherapists. This suggests that there is an overall shortage of health professional resources which is a larger challenge than the distribution between public and private.

84. The Percept work[21] indicates shortages across critical healthcare categories. Amongst general practitioners (GPs), 18.9% of total posts remain unfilled, with provincial differences ranging from 52.9% in Limpopo to 2.8% in the Western Cape. Amongst professional nurses, 12.9% of posts are vacant, with provincial differences ranging from 35.1% in Limpopo to 2.6% in the Northern Cape. Some 22.5% of psychologist posts remain vacant, ranging from 35.9% in Limpopo to 4.8% in the Northern Cape. Vacant posts are distinct from frozen posts which are not generally reported in the HR budget. If included, the extent of shortages increases.

[20] Percept (2019). Human Resources for Health: Key perspectives on supply and absorption.

[21] Percept (2019). Human Resources for Health: Key perspectives on supply and absorption.

85. Using a combination of Persal salary data and data from provincial sources, Percept estimates the annual cost of filling unfilled posts for these particular cadres at R10.3bn. This may be understated due to the inconsistent reporting levels across provinces. It is also noted that there is tension between the National and Provincial department regarding the allocation of funds to health payroll with regard to internship and community service. This is also likely to be a lower bound estimate.

86. The total payroll for public sector health professionals in the cadres analysed is estimated at R70bn which is 58% of the total Department of Health payroll. It would therefore be prohibitively expensive for the State to fill all unfilled critical healthcare worker positions in the public sector and to expand this to all healthcare workers. This will clearly not be feasible given current fiscal constraints, or significant changes to current budget allocations. Additionally, as found by Percept, a minimum of 35% of specialists work in both private and public sectors and there is limited data available on this which suggests a greater need for monitoring and management of this existing framework. There is very limited data on RWOPS[22] which suggests that this is an area of uncertainty that can potentially have a large impact on the availability of human resources in both the public and private sectors.

87. Overall this suggests that there is a need to review how current funds are allocated with respect to professional health resources. It also indicates that there is a massive crisis in health resources particularly at GP and Specialist level and that the strategies to address this need to go beyond simply combining public and private and focus on expanding the number of healthcare professionals in South Africa. The private healthcare sector is seeking to work more collaboratively with the public sector on supporting greater levels of healthcare education.

88. Given current human resource constraints, a better model would therefore be for the NHI to contract with GPs, specialists and other healthcare professionals, while allowing them to supplement their income through private practice funded by medical schemes. Rather than solving the human resource constraints, a big bang approach, as introduced in section 33 will lead to a decline in the number of specialists (and associated medical personnel) as they would not be willing to accept large declines in their income. This is supported by the experience in other middle-income countries where there has been a loss of medical skills in response to radical reform in health system regulations (for example in Ghana most doctors are employed in the public sector, yet 64% of their income is derived from patients paying out of pocket (OOP). There were high levels of physician emigration (between 50%-75%) following the introduction of the NHIF.

22 Remunerated work outside the Public Sector.

5.4.3 Loss of current cross subsidies of pharmaceuticals and medical equipment in the public sector by prices charged to the private sector.

89. It is BUSA's view that the private healthcare sector is an important asset. Similar to the case of doctors and healthcare workers described above, the pharmaceutical sector currently supplies medicines to the state at discounted prices, as fixed costs such as infrastructure, investment and research and development are covered largely by revenues from the private sector. This status quo ensures a consistent and sustainable supply of medicines to the country. Research has found that the median multiple of private over public price was 3.6, with half of the values falling between 1.8 and 6.8. This means that implementation of a single fund model will necessitate an increase in the price of pharmaceuticals and medical equipment to the public sector by between 24% and 174%.

90. Allowing a differentiated pricing system aligned to the economic, industrial and patient access imperatives of our country is the best form of ensuring security of supply and optimal therapeutic outcomes. A pricing and/or procurement that disrupts this model is likely to unintended consequences on medicines security of supply and manufacturers and supplier's sustainability in market.

91. The inclusion of section 33 significantly undermines the viable delivery of services by doctors, as well as products by pharmaceutical companies, and as we show below, this is also the case for private hospitals.

5.4.4 Impact on the rights of individuals to purchase healthcare cover

92. BUSA/B4SA further notes that there is similarly no rationale for the proposed amendments to the Medical Schemes Act which include significant and material changes to the business of a medical scheme which severely limit the rights of medical scheme members. It is particularly concerning that no rationale has been presented for the limitation of maternity benefits.

5.4.5 Ability to attract investment into the healthcare sector

93. Investment in the healthcare sector is required in terms of ensuring that there are adequate healthcare facilities as well as a pipeline of healthcare professionals to deliver care. Investment in health technology that promotes access to healthcare is also critical to addressing the policy goals. There is a particular need to enhance the primary healthcare capacity in South Africa and there are immediate opportunities to encourage investment in supportive modes of delivery. This is a clear opportunity for public private partnerships.

94. The Bill has had a negative impact on investor sentiment which has implications that are wider than just the healthcare sector. The single fund model requires the management of complex resources and there are substantial operational risks which would affect access to care.

95. In addition, no alternative system to achieve UHC is being considered. Significant improvement in the public healthcare sector can come about with much smaller changes than a complete overhaul of healthcare financing. From an investment perspective, this is irrational policy-making. At an economy-wide level, this is particularly dangerous for South Africa. The current economic climate requires a steady-hand and well considered policy. The inclusion of Section 33 in the Bill is the opposite of this.

96. In combination with an uncoordinated policy process and the lack of adequate healthcare infrastructure to support an NHI system as contemplated in the Bill, (discussed in Section 4.4), the impact of NHI on investor sentiment in both the healthcare sector and in the country more broadly, is significant and hampers the capacity for recovery following the COVID-19 pandemic.

97. Policy changes that affect private sector service provision will have a ripple effect throughout the economy, with any impact on private healthcare provider affecting suppliers to this sector, and suppliers to these suppliers. Ultimately, this multiplier effect means that factors affecting private sector healthcare providers will have an economy-wide effect across variables such as employment, labour remuneration, GDP, and fiscal revenue. The impact of the NHI Bill on private sector suppliers must take account of this far-reaching economic impact, and must consider the knock-on effects within industries with even a distant link to the private healthcare sector.

5.5 Legal Concerns

5.5.1 Limitation of constitutional right to access to healthcare

98. Section 33 of the NHI Bill is an infringement of the right of access to healthcare per section 27(1)(a) of the Constitution because medical services that fall under NHI coverage are likely to be inferior (in quality and/or extent) to the same medical services that medical schemes currently cover.

99. This was also found by the HMI in their final report (page 66, 67): "We did not consider public healthcare facilities to be a reasonable alternative to the services of private facilities (see PFR page 175; para 54-56).".

100. FTI finds that the implementation of section 33 is likely to result in private healthcare facilities becoming unable to cover their cost of capital. Ultimately, this will have a negative effect on investment for private healthcare facilities, which will impact on the sustainability of the business model and the NHI Fund's ability to source such services.

101. There are numerous other facts that would reasonably lead one to believe that NHI cover will be inferior to current levels of care in the private sector. Just by way of example, these include: (i) the condition of public hospitals in Gauteng - it will cost approximately R6bn to make them compliant with the Occupational Health and Safety Act;[23] and (ii) the magnitude of medical negligence in public health facilities as evidenced by the principal amounts paid out for litigation on behalf of the Department of Health by the offices of the State Attorney (R498,964,916 in the 2013/2014 financial year).[24]

102. The restriction of the role of medical schemes to 'complementary' coverage undermines the right and ability of an individual to insure against the risk (or refusal) by the NHI Fund to provide prescribed services.

103. The legislated limitation on the role of medical schemes is not necessary to achieve a single-payer healthcare system, i.e. there are less restrictive means to achieve NHI's purposes. These include allocating more funds to the public sector, filling vacancies in public hospitals, increasing capacity at medical schools, and a proposed hybrid NHI model that still accommodates medical-scheme coverage for NHI-covered medical services.

104. A comparative analysis of other countries including Brazil, Chile and the UK, shows that it is not necessary to abolish private insurance to successfully implement a single public payer system.

[23] https://www.timeslive.co.za/news/south-africa/2019-11-04-r6bn-needed-to-fix-32-gauteng-hospitals-to-be-safety-compliant/

[24] See the South African Law Commissions issue paper 33 project 144 on Medico-Legal Claims, paragraph 2.22 https://www.justice.gov.za/salrc/ipapers/ip33_prj141_Medico-legal.pdf

105. No rationale has been presented for the limitation on the rights of medical scheme members introduced in the 2019 version of the Bill and there is particular consideration required for the transition period when these members will be required to pay additional taxes without concomitant access to benefits.

6 Cross-subsidisation between private and public sectors will guarantee the sustainability of the healthcare system

106. In this section we show that cross-subsidisation of the public health sector is key to the viability of this sector and can be the basis for further systems strengthening initiatives. Further, the current NHI proposals have assumed that such cross subsidy will continue while at the same time eliminating the opportunity for it to take place (which is not rational).

107. Allowing specialists to continue to do some private work will be essential to ensure that doctor salaries remain globally competitive and that these vital skills are retained in South Africa. In the short to medium term, prudent design of a transition glide path will be key to avoiding drastic reductions in income and the potential departure of large numbers of specialists.

108. It is our view that allowing a vibrant medical scheme market will benefit South Africa as a whole. As well as ensuring sustainability through differential pricing, retaining medical schemes maintains people's freedom to purchase health services at the level they wish after paying for NHI, which is the global norm and, as such, important for South Africa's business environment and international competitiveness.

109. BUSA/B4SA acknowledges that there are opportunities for increasing efficiencies in the private sector through recommendations such as implementing reimbursement mechanisms that promote multidisciplinary practices and reward quality outcomes. Such initiatives (some of which require regulatory changes) have the potential to address inflationary pressures and the cost of private cover which will enhance access, reduce the burden on the State and enhance UHC.

110. The HMI made a number of recommendations to enhance efficiencies in the private health sector and specifically noted the opportunity for greater collaboration with the public sector. These recommendations included:

i. Amendments of the Health Professions Council of South Africa (HPCSA) rules around multidisciplinary practices, employment of doctors and doctor shareholding in facilities to support more favourable contracting in the industry for the benefit of consumers.

ii. Government to promote the development of alternative reimbursement models and risk sharing mechanisms with a focus on quality outcomes. This will benefit schemes through improved affordability of cover.

iii. HPCSA to consider assisting in updating the learning curriculum so that medical graduates will understand the cost implications of their decisions

iv. The National Department of Health to initiate a co-ordinated approach for the establishment of supply side regulation and facilitation of more appropriate contracting mechanisms

v. Improvements to scheme governance as proposed in the Medical Schemes Amendment Bill and recommendations relating to enhanced risk pooling for medical schemes.

111. The bulk of these recommendations require regulatory actions which are within the ambit of the Department of Health. The failure to implement these recommendations has led to ongoing escalations in the cost of medical scheme cover. It is therefore circular for the Department of Health to refer to escalations in the cost of medical scheme cover as a basis for limiting the role of medical schemes when it is within the Department's authority to implement the necessary regulatory amendments to address this.

112. The HMI did not find evidence of excessive profits in the private health sector.

7 Definition of milestones and phased implementation

113. BUSA/B4SA notes that the phased implementation of the NHI Fund as proposed in the NHI Bill 2018 was updated in the 2019 Bill simply by renaming the phases but without any evidence that the objectives set out for phase 1 as defined on the 2018 NHI Bill have been achieved. Further, the dates for the phases have simply been shifted out for 5 years without any assessment of the requirements to achieve these, particularly considering the effect that the COVID-19 pandemic has had on the South African health system and the economy.

114. It is not appropriate or sound legislative drafting for phases to be defined with reference only to dates rather than in terms of clear and measurable objectives that need to be achieved and that there is a process of independent measurement and verification of this. This is an important requirement of an inclusive democratic process.

115. In terms of section 58 of the Bill, the legislation set out in the schedule to the Bill ("**Schedule**") will, "*subject to [section 58] and section 57 dealing with transitional arrangements*" be repealed or amended as provided for in the Schedule. In terms of section 57 of the Bill, the NHI scheme will be implemented in two phases, namely phase 1 and phase 2, each of which are given greater content in sections 57(2), 57(3) and 57(4). Both phase 1 and phase 2 are required to be completed within specific time frames, namely:

- phase 1 is to be completed between the period 2023 to 2026 (2017 to 2022 in the 2019 version); and
- phase 2 must be completed between the period 2026 to 2028 (2022 to 2026 in the 2019 version).

116. As part of the second phase of implementation, various activities in respect of legislative reform will be undertaken to enable the introduction of the NHI scheme, including effecting changes to a host of legislation. It is not clear from a reading of section 58 and section 57 of the Bill, when these legislative reforms (as set out in section 57 and the Schedule), will take effect – on full implementation (which has not been defined), or at some time during phase 2.

117. We believe that it is premature to set out in legislation and contemplate in the Bill the amendments that will take effect during, or on full, implementation of the Bill. This is because, during the phased implementation of the Bill, it may become apparent that many of the amendments to the existing legislation set out in the Schedule need to be re-considered or amended. Once the Bill is enacted, if it becomes apparent during the implementation of the Bill that amendments to the provisions of the Schedule are required, these can only be effected through the passing of an amendment to the Act (i.e. an amendment bill).

118. Given that, as currently drafted, the full implementation of the Bill is date-dependent, the need to pass legislation to effect amendments to the Schedule, which is an extensive process, may result in the NHI scheme taking effect without the necessary amendments to the Schedule being made prior to the end of 2028.

119. BUSA/B4SA suggests that the proposed amendments to the existing legislation should be deferred or suspended, and that an undertaking be included in the Bill to the effect that, legislative reform will only be considered, once it is clear that: (i) the NHI scheme is practically possible in the form contemplated in the Bill; (ii) that the NHI scheme can be carried out without the support of the existing legislation; and (iii) that making changes to the existing legislation will not be irrational, nor impact on the continuity of healthcare services available to eligible users.

120. Until such time as the healthcare system as a whole (public and private) in South Africa is able to deliver healthcare services of good quality within a reasonable time, then it should not be the case that the Minister can, through regulation (as contemplated in section 33 of the Bill), determine that the NHI system has been “fully implemented”. If the NHI scheme is implemented in full on an arbitrary date in 2026, notwithstanding the fact that healthcare service delivery has not been improved both qualitatively and in terms of waiting times, then the NHI scheme (and the Minister’s determination to this effect) may be subject to legal and constitutional concerns.

8 Governance and structures

121. BUSA/B4SA notes that the NHI Fund is proposed as a public fund in terms of the Public Finance Management Act (PFMA). BUSA/B4SA has concerns regarding the power vested in the Minister in terms of key appointments across the NHI Fund and related entities without the oversight of Parliament which is a requirement of our Constitutional democracy. Such appointments should also be made in a way that is consistent with good governance requirements that includes the identification of qualification, skills and experience requirements. These processes need to address both the appointment and removal of such positions.

122. BUSA/B4SA notes with concern that private sector involvement has not been incorporated in the Stakeholder Advisory Committee and the role of this Committee in the overall governance of the NHI Fund is unclear. There is no link specified anywhere in the NHI Bill to any of the other structures of the NHI Fund.

123. The exclusion of the Competition Act has not been substantiated including the potential adverse consequences on the ability of the NHI Fund to contract with the limited supply of healthcare providers in South Africa. This is particularly concerning since the Health Market Inquiry has identified and explored the complexities of competition issues when applied to health care markets and these are important factors to consider in ensuring that ultimately care is delivered in a patient-centric way that is focused on quality outcomes while ensuring efficient use of resources. The recommendations of the Health Market Inquiry including any legislation required to implement these recommendations, will also need to be aligned with what is contemplated in the NHI Bill.

124. We are also concerned about the degree to which governance and decision-making is centralised in the office of the Minister of Health and a limited number of committees, in the NHI Bill. We understand that the rationale is to create an NHI Fund that will be a single purchaser, with the ability to contract with all providers at the lowest price. There is a role for centralised standard-setting, accreditation procedures, overall resource allocations, benefit frameworks and reference tariffs, but these require independent expert authorities and supportive research, consultation and negotiation processes.

125. The architecture of health system decision-making also requires extensive decentralised resource allocation, contracting and cost-recovery arrangements, involving consideration of diverse needs and available resources, alongside detailed specifications of coverage and standards. When standards, delivery requirements or prices are mis-specified, or trends in healthcare needs are not fully anticipated, then supply falls short of demand and services are likely to be rationed through queues and delays. Universal coverage, in practice, involves a series of reforms that expand access to enhanced services as economic growth and resource availability permits. A centralised committee process for managing the evolution of health services can oversee broad trends, benefit specifications and resource allocations, but the management of resources, contracts, approvals of expenditure and service delivery assurance, amongst other functions, require decentralised administrative capacity.

126. There are, in our view, compelling arguments in favour of *competitive* arrangements for benefits administration and health service provision, even within a regulated NHI framework. Many countries have successfully proceeded along this route, building on the capacity of decentralised governance and decision-making arrangements, with service delivery contracting founded on regulated negotiation and procurement processes.

9 Immediate opportunities for advancing universal health coverage (UHC)

127. The NHI, if sustainably funded and appropriately configured, can dramatically improve the level of overall health care in South Africa. Critical to this is harnessing the deep and valuable experience, resources, capacity, advanced technology, systems and track record that exists within the private health care sector, including hospitals, GPs, specialists, nurses, ambulance services and medical aids. These world-class resources can be leveraged to support the delivery of a robust and sustainable NHI model that benefits all.

128. There are immediate opportunities to enhance access to healthcare services in South Africa. These opportunities are entirely consistent with the policy objectives set out in the NHI Bill and include:

- Contracting private sector facilities to use excess capacity for public patients – this could have immediate benefit to patients in dire need for care (such as for oncology services and other critical areas where public sector facilities are inaccessible).
- Incorporating private sector training platforms for expanding the pipeline of healthcare professionals to address the shortage – which is anticipated to worsen as current professionals retire.
- Implementing low cost benefit options on medical schemes with primary care benefits consistent with the principles of the NHI benefit package to harness private sector funding for these benefits without the need to raise taxes. This could lead to a common benefit package across medical schemes and the NHI Fund but there are immediate benefits for economic productivity and social benefit for an estimated 5m to 6m lives.

129. The benefits of constructive public-private partnership were clearly evident during the COVID-19 pandemic, when the private sector pooled its skills, capacity, and funding to support government efforts.

10 Recommendations

130. BUSA/B4SA supports social justice, human rights and democratic values as enshrined in the Constitution of SA. The key objective of universal healthcare coverage (UHC) is supported by Business. However, it is it is possible to create a single public payer without limiting the role of medical schemes.

131. The severe restriction of medical schemes (and the private sector under section 33) will not improve access to quality healthcare for all South Africans. There is therefore a need to explore alternative mechanisms towards UHC.

132. BUSA/B4SA requests the Committee to consider carefully the detailed submissions accompanying this document. It will be very clear from these submissions that the inclusion of section 33 in its current form creates an extremely negative environment for business and in fact will have such negative unintended consequences that it will undermine the goals of UHC. We therefore urge the Committee to amend this section of the Bill. If medical scheme members give up their cover in the short term before there have been any meaningful changes in public sector delivery capacity, there will be additional burden on public sector resources making healthcare system strengthening all the more challenging.

133. There is a clear need for detailed modelling and forecasting to project the resource requirements for the proposed system reforms. BUSA/B4SA recommends that this is undertaken in a transparent and inclusive way starting with the publication of the costing work prepared by National Treasury and engagement on these.

134. The recommendations of the Health Market Inquiry also include a number of mechanisms that will enhance efficiencies in the private sector and have immediate benefits on the cost of cover immediately. A key recommendation relates to the Health Professions Council of SA (HPCSA) rules that would facilitate value-based contracting on a patient-centric basis. BUSA/B4SA urges consideration of these recommendations.

135. There are significant health risk management skills in the private sector which can be harnessed to contribute to developing a sustainable framework. Initiatives around health system strengthening included in the Health Compact are evidence of the feasibility of such a collaborative approach.

136. There is clearly a significant shortfall in the availability of professional healthcare resources across the whole system and urgent action is required to address this. BUSA/B4SA members include stakeholders from across the health sector who are willing to contribute constructively to the development of human resources for health (HRH) plans to address this crisis.

10.1 Specific recommendations:

137. The NHI Bill requires substantial review to ensure that there is a clear and rational framework for implementing the NHI Fund and that the scope for interpretation challenges is limited. This requires:

i. Clear definitions and consistent use of terminology throughout the Bill as set out in the line by line commentary appended to the 2019 submission.

ii. Section 33 of the Bill is unnecessary for attaining the policy objectives and introduces significant risk due to the single fund model and the adverse impact on people's ability to seek care in the private sector. The role of medical schemes, as set out in section 33 of the NHI Bill should be amended to allow for the coexistence of the NHI and medical Schemes. We would propose replacing the current version of section 33 with wording along the lines of the following: "*Once National Health Insurance has been fully implemented as determined by the Minister in consultation with the Benefits Advisory Committee and the Stakeholder Advisory Committee, the Minister shall publish notice of such determination in the Gazette, and may make regulations regarding the role of medical schemes consistent with the objective of the progressive realisation of access to quality healthcare services by users of the Fund*".

iii. The contracting provisions in Sections 11 and 26 of the Bill are unsustainable and inconsistent with the principles of value-based care which is the global trend for sustainable healthcare contracting that is patient centred. Proposed amendments included by BUSA/B4SA aim to ensure a sustainable contracting basis.

iv. The phased implementation in Section 57 of the Bill has been linked to the dates rather than to milestones that are relevant to South Africans having reasonable access to quality healthcare services.

v. The legislative changes included in Section 58 of the Bill appear to be immediate in effect which is in conflict with the provisions of Section 31 of the Bill and results, for example, in the immediate removal of health functions from the Provinces which impacts around R196bn of funding which is currently paid to Provinces. No plans for implementing these massive shifts in funding and functions have been published for discussion/consultation and this has ramifications on the rights of employees as well as service delivery. Proposed amendments to Section 57 of the Bill aim to clarify that phasing is based on attainment of milestones rather than fixed dates. The legislative changes proposed for immediate implementation under Section 58 of the Bill are premature and require consultative processes and transitional planning and hence should be removed.

vi. The sources of funding set out in Sections 48 and 49 of the Bill are the remit of National Treasury and should be dealt with in a Money Bill in accordance with the Constitution.

vii. There are serious concerns regarding the right of access to health services created by provisions in Sections 7 and 45 of the Bill. The amendments to Section 33 of the Bill will address this issue which is of constitutional significance.

viii. There are conflicts with the Competition Act and the Protection of Personal Information Act which need to be addressed in consultation with the Competition Commission and the Information Regulator

138. Our submission is based on extensive research by experts in the field. We reference the research throughout our submission, which was included as Annexures to the BUSA submission to the Portfolio Committee on Health of 29 November 2019. The Annexures contain a wealth of research and data which we believe will inform the work of the Committee in considering the impact of the detail of the NHI Bill.

139. BUSA/B4SA would welcome the opportunity to engage further with the Committee on these vital issues.

11 Annexure:

- Schedule of proposed amendments to the NHI Bill

List of Annexures to the BUSA submission of 29 November 2019:

- Line by line commentary on the NHI Bill.
- FTI Note 1 (2019). "HEALTHCARE PROVISION UNDER NHI: CONSIDERATIONS UNDER SECTION 33". Commissioned by BUSA.
- FTI Note 2 (2019). "INVESTIGATING EXCESS CAPACITY IN THE PRIVATE HEALTHCARE SECTOR AND THE EFFECT OF PRICE REDUCTIONS UNDER SECTION 33". Commissioned by BUSA.
- FTI Note 3 (2019). "SOUTH AFRICA'S MACROECONOMIC CLIMATE AND THE IMPLEMENTATION OF SECTION 33 OF THE NHI BILL". Commissioned by BUSA.
- PERCEPT (2019). "Human Resources for Health: Key perspectives on supply and absorption". Prepared for Business Unity South Africa (BUSA). Commissioned by BUSA.
- INSIGHT ACTUARIES (2019). "A Transitional Framework for achieving Universal Health Coverage in South Africa". A research report for Business Unity South Africa.