1. Introduction

The Helen Suzman Foundation ("**HSF**") is a non-governmental organisation whose main objective is to defend the values of our constitutional democracy in South Africa, with a focus on the rule of law, transparency and accountability.

The HSF has had an active interest in the health system for several years, and it has submitted comments on the National Health Green and White Papers. The HSF welcomes the opportunity to make submissions to the Department of Health on the National Health Insurance Bill, 2018 ("**NHIB**") and the Medical Schemes Amendment Bill, 2018 ("**MSAB**").

2. Summary

Section 27 of the Constitution confers on everyone the right to access health care services and places an obligation on the state to take legislative measures to achieve the progressive realisation of this right. We support reasonable endeavours that seek to advance the progressive realisation of the right to health care for all South Africans.

The NHIB and the amendments proposed to the Medical Schemes Act, 131 of 1998 (**"MSA"**) by the MSAB purport to do this. However, the HSF will argue below that the proposed changes to the health care sector, both in the public and private spheres, will not effectively advance the right to health.

Before embarking on the substantial comments, a procedural issue must first be flagged. Taking our cue from Rule 276(5) of the Rules of the National Assembly ("**Rules**"), if a draft Bill is published, a memorandum setting out the object of the Bill must also be published. The explanatory memorandum is a helpful aid to understanding the context and purposes of the Bill introduced in the National Assembly. The draft MSAB and the draft NHIB are not accompanied by any explanatory memorandum. Without it, the reader is forced to try to understand the proposed provisions without any context or insight into the objects of the draft Bills, or the intention of any amended provisions. By failing to include an explanatory memorandum, the public is unable to fully engage with the substance of the Bills.

The HSF recommends that the following approach be taken by the Portfolio Committee:

a) That the MSAB await the final report of the Health Market Inquiry and that an amended version be published, with references to National Health Insurance deleted. The

rationale for other changes needs to be explained fully in the accompanying explanatory memorandum.

b) That the NHIB be withdrawn, and replaced by measures to strengthen the provision of health services by the government, with special consideration given to servicing unmet need.

3. The health status of the South African population

Key indicators are set out in Appendix 1. South African mortality risk is well above the global level[1], and much worse than other countries at our level of gross domestic product per capita in purchasing power parity terms[2]. Life expectancy at birth dropped sharply with the onset of the HIV/AIDS epidemic[3]. According to the World Health Organisation (**"WHO"**), only two countries had a higher incidence of HIV infections and none had a higher incidence of TB infections in 2016[4]. The decline in life expectancy has been reversed, but at the cost of imposing a heavy and rising burden of the primary HIV/AIDS and TB programme on district health services. Expenditure on these programmes is budgeted at 37.2% of district health expenditure (excluding district hospitals) in 2018/19[5]. Non-communicable disease is also prevalent. Only 18 countries had worse mortality from non-communicable diseases between the ages of 30 and 70 than South Africa[6].

Measuring morbidity (disease while alive) is more complex. One approach is to discount years of life spent in morbid states by factors based on their severity. This creates a difference between life expectancy and health adjusted life expectancy. The WHO estimates that the gap was 7.9 years in South Africa in 2016. In all but the youngest age group (0-4), most days lost each year were as a result of non-communicable diseases[7].

The health status of a population depends mainly on living standards, education, environmental factors, epidemic and endemic infectious diseases and life styles (including risky behaviour). The provision of health care services, essential as they are, is only one determinant of population health status.

4. The private sector and the Competition Commission's Private Health Market Inquiry into Private Health Care

[1] Appendix Figure1
[2] Appendix Table 1
[3] Appendix Figure 2
[4] WHO, World Health Statistics
[5] National Treasury, Provincial budgets, Health votes, 2018
[6] WHO, World Health Statistics
[7] Appendix Figure 3

The private health sector, while more efficient at providing health services than the public sector, is not exempt from problems of its own. The issues facing the private sector were recently explored in detail in the provisional report of the Competition Commission's inquiry into the health market.

Issues identified include high and rising costs of healthcare and medical scheme cover, highly concentrated funders and facilities markets, disempowered and uninformed consumers, a general absence of value-based purchasing, ineffective constraints on rising volumes of care, practitioners that are subject to little regulation, and failures of accountability at many levels.

The Commission came to the conclusion that numerous failures exist in the private health sector which require intervention. Failure to intervene could see individuals, currently obtaining services in the private sector, becoming unable to afford such services, increasing the strain on the public health sector. In order to overcome these failures, attention to all the Commission's recommendations will be important. Merely confining attention to a subset of them will not produce the desired results, and may even make matters worse. A revised, improved MSAB, focused solely on the private sector, should deal with all the medical aid issues identified in the final report of the Commission.

5. The status of the public health sector

The existence of a diagnostic report of the problems of the private sector is not matched by a corresponding report for the public sector. Section 54 (2) (a) of the NHIB provides that:

> Phase 1 [of implementation] encompassed a period of five years from 2012 to 2017 and included testing of effective health system strengthening initiatives.

This Phase is now complete, but there has been no report published on its outcomes. We believe that the National Department of Health owes the country such a report, which should outline where strengthening is needed, and describe the outcome of the testing of initiatives. In particular, Phase I appraisal reports should be published in their entirety. We encourage voluntary publication on their completion, which would remove the need for interested parties to resort to administrative or legal action in order to access the information.

The establishment of the Office of Health Standards Compliance has been a step forward, but the results of its first inspection (in 2016/17) are alarming. Only seven out of 851 inspections found health establishments fully compliant with requirements, with a score of above 80%. By contrast 532 establishments were assessed as non-compliant or critically non-compliant, with scores of below 50%. Inefficiencies identified included the shortage of doctors, especially in rural areas; long distances to the nearest hospital; medical supplies, and equipment failure, which result in patients not being able to receive surgical treatment; medical legal claims and accrued contingent liabilities are a significant financial burden, as are rising personnel costs. Patients have also reported issues, including cleanliness; drug availability; incorrect diagnosis and long waiting periods. Above all, it is evident from the report that many of the defects are managerial, with lack of oversight and timely

intervention whenever there is delivery failure, and lack of accountability at national and provincial level.

The managerial problems support our central contention that it would be counter-productive to direct scarce managerial capacity in the public health system to a major overhaul of the funding and contracting system while so many in-facility management problems remain. We also do not believe that the government has the capacity, or will have it in the foreseeable future, to run the NHI Fund. Two examples illustrate the point:

There have been difficulties, still not fully resolved, with the social grant system ever since the Constitutional Court declared its contracts to deliver grants illegal in 2014. And the social grants system is much simpler than the NHI would be. Social grants require only that beneficiaries be identified and paid. The NHI Fund would have to be informed of changing best medical practice and its costs, incorporating them in benefits design and pricing, in accordance with funds received each year and patterns of utilization, contract with a multitude of health care providers, and ultimately manage more money than the social grants system.

Similar problems have been found with the land restitution process. Twenty years after the closing date for the first round of applications, 7 000 claims remain unsettled and 19 000 are not finalised. At the current rate of progress, the second round of claims already lodged will take over 140 years to process[8].

6. The NHI Bill

The major difficulty with the NHIB proposals is the disconnection between the financial changes it seeks to introduce on the one hand and implementation challenges on the other.[9] What the current health system requires is a reform that substantially addresses the issues facing the public health system, on which many people will continue to rely.

The HSF believes that the reform proposed by the NHIB will not substantially address the implementation issues. It will instead worsen inefficiencies by increasing the administrative burden. The NHIB fails to address several issues which desperately require intervention.

Some terminology needs discussion. A health care provider in the NHIB is as defined in Section 1 of the National Health Act ("**NHA**"), and means any person providing health services in terms of any law. A health establishment is as defined in Section 1 of the NHA as the whole or part of a public or private institution, facility, building or place that is operated or designed to provide inpatient or outpatient treatment. A service provider is defined in Section 1 of the NHIB to be a health care provider and a health establishment.

[8] Parliament of South Africa, Report of the High Level Panel on the Assessment of Key Legislation and the Acceleration of Fundamental Change, November 2017, p 238
[9] SAHR 2017

Section 5(1)(d) of the NHIB empowers the NHI Fund to enter into contracts with certified and accredited public and private service providers. A certified service provider is a provider in possession of a certificate of need issued by the Director-General of the National Department of Health, as provided for in Section 36 of the NHA**.** Accreditation is governed by Section 38 of the NHIB, and requires certification by the Office of Health Standards Compliance, registration with professional councils where relevant, and satisfaction of a list of criteria, including provision of a minimum range of personal health care prescribed by the Minister, adherence to treatment protocols and guidelines, health care referral networks, and to the national pricing regimen for services delivered. Accreditation must be renewed every five years.

6.1 Eligibility and user rights and obligations

Citizens and permanent residents are entitled to full benefits from the NHI Fund. The rights of refugees and asylum seekers are restricted to emergency health care, services for notifiable conditions of public health concern, and paediatric and maternal services at the primary health care level. Temporary residents have the right to emergency medical treatment and any other health service covered by mandatory travel insurance. The restriction on access by refugees conflicts with Section 27 of the Refugees Act, which provides:

> *A refugee-*
> *(b) enjoys full legal protection, which includes the rights set out in Chapter 2 of the Constitution and the right to remain in the Republic in accordance with the provisions of this Act;*

Accordingly, a person granted refugee status is entitled to the rights set out in Section 27 of the Constitution and the progressive realisation of these rights. It would be an unconstitutional discrimination to limit the services for which the NHI provides based on refugee status.

All eligible persons must register him or herself and his or her dependants with the Fund at an accredited public or private health care establishment.

Section 9(o) gives the right to users to purchase complementary health benefits that are not covered by the Fund through a voluntary medical insurance scheme registered in terms of the MSA, any other private health insurance scheme, or out of pocket payments. Section 10(2)(c) requires that users must adhere to the referral pathways determined by a health establishment and they are not entitled to health service benefits purchased by the Fund if they fail to adhere to the referral pathway in question.

Section 12(1) states:

> A person who is registered as a beneficiary in terms of this Act must receive such health service benefits purchased on his or her behalf by the Fund from certified and accredited service providers at no cost.

It was probably intended to mean that *if* a beneficiary receives a health service covered by the Fund and the service is provided by a certified and accredited service provider, *then* that service should be

free at the point of service delivery. But it could also mean that a beneficiary must *both* receive a health service covered by the Fund from a certified and accredited service provider *and* the service should be free at the point of service delivery.

Here we arrive at a core issue. The HSF advocates a health care system which enables and empowers users, rather than coercing them by constraining their options. Our interpretation of the NHIB is that health care providers are not obliged to be accredited in order to practice, and that the NHI Fund is not obliged to enter into contracts with all accredited providers. Moreover, Section 38(4) of the NHIB requires that a contract with a service provider must provide a clear statement of performance expectations in respect of the management of patients, the volume and quality of services delivered, and access to service. The volume specification makes it possible for an accredited health care provider to enter into a contract for part of his or her time, but not all of it. Such contracts would continue the current practice, by which doctors offer part of their time to the public system and it would also accord with practice in the United Kingdom, particularly among specialists. Health care providers would then fall into three categories: (a) those with a contract with the NHI Fund for all of their time (b) those with a contract with the NHI Fund for part of their time and (c) those with no contract with the NHI Fund.

What, then, are the options facing a user who wishes to purchase a service from a health care provider, either in category (b) during their non-NHI time or in category (c), which is not covered by the NHI Fund? Section 9(o) of the NHIB cannot, by itself, remove the right to do so and pay out of pocket, which would be the only option to the extent that medical aid schemes are prohibited from covering these services in terms of the addition of Section 34(3) of the MSA by the MSAB. But Section 12(1) may exclude even this possibility, if it means that a Fund beneficiary must receive such services from certified and accredited service providers. This is a major constraint on user choice, undesirable in itself, and likely to lead to considerable user resistance. In addition, some users will want to use an accredited service provider for some NHI-covered services and non-accredited service providers for others. For instance, a user might want to consult a non-accredited GP, but nonetheless be willing to acquire medicine that the GP prescribes from an accredited pharmacist. It is not only the affluent who will want these options. At present, many people of modest means prefer to use doctors in the private sector than receiving services from the public sector at lower cost. Many will continue to do so even in the presence of compulsory NHI contributions, which will be seen merely as additional taxation.

Further difficulties arise in the referral system. Section 11(2)(b) of the NHIB provides that a user will not be allowed to seek the services of specialists and hospitals without first obtaining a referral from his or her health care provider, except in cases of emergency. Section 12(2)(b) provides that a user who fails to comply with referral pathways determined by health care providers or health establishments must pay for the services rendered directly, or through a voluntary medical insurance scheme or through any other private insurance scheme. Section 6(1)(i)(iv) requires the Fund to identify, develop, promote and facilitate the implementation of best practices in respect of health care referral networks.

The implicit model seems to be that if a user has a health problem which can be treated by a Fund service, the user will go to an accredited service provider in the first instance. If that provider is

unable to treat the problem fully, the user is then referred along a health services network established by the Fund, possibly ending up with a specialist with an NHI Fund contract and/or a hospital with an NHI Fund contract. Oddly, Section 12(2) provides that a person can be covered by a medical aid scheme if he or she does not comply with referral pathways.

But the implicit model does not cover all the possibilities. For instance, one might start with a GP without a Fund contract. Can he or she refer you to a specialist or a hospital with a Fund contract? And if this is possible, will the specialist or hospital service be free of charge at the point of service? And what would happen if a health problem that the user initially thinks can be treated by a Fund service, turns out not to be so treatable?

In short, the system as set out in the NHIB does not deal with all the situations which may arise. It implies coercion of users, which may turn out to be extensive. Neither represents a satisfactory state of affairs.

6.2 Resources

We are astonished at the recklessness of the Minister of Health about the resources needed for the NHI. He is reported as saying:

> To calculate how much NHI will cost [in its entirety] is an impossibility, the World Health Organisation told us.

and

> It is the function of the Treasury and government of the country to sit down and see where the money will come from.[10]

This means that the government intends parliament to pass the NHI Bill without information about the cost of NHI, or even the instruments used to fund it. More cynical observers than ourselves might conclude that this allows the government the political advantage of displaying the benefits of NHI while obscuring its costs. But the services which the Fund can offer will depend on the Fund's revenue, so even the benefits can only be described in general terms, leaving the details to the Benefit Advisory Committee which may be established by the Minister in terms of Section 25 of the NHIB and the NHI Fund.

In retrospect, the Benefit Advisory Committee and the Health Benefits Pricing Committee, established in terms of Section 26 of the NHIB, should have been constituted at the beginning of Phase 1, and they should have issued a report on five years of work at the end of that phase. The two committees could have started with existing public sector treatment protocols, considered additions to them, and worked out prices of health service benefits. The addition of estimates of the numbers of each service required annually would have allowed a first pass estimate of Fund treatment costs. In the process, the demand for health care providers in various categories would have had to be estimated.

[10] Lameez Omarjee, Impossible to calculate how much NHI will cost – Motsoaledi, Fin24, 21 June 2018

Financial resources are one constraint. Human resources are another. They are elastic, since the supply of certified and accredited individuals willing to contract with the NHI will depend on the prices of health service benefits. The higher the price, the greater the supply, but also the greater the impact on the NHI Fund revenue requirement. Moreover, categories of health service providers can be put on the special skills list for immigration purposes. As the WHO puts it:

> the purpose of health financing is to make funding available, **as well as to set the right financial incentives to providers, to ensure that all individuals have access to effective public health and personal health care (our emphasis)**."[11]

But, although responsive to prices, human resources supply has limits. In the short and medium runs they are partly shaped by historical patterns of demand. In the public sector, most users are seen by a nurse in the first instance, who treats them if possible, or refers them to another service provider. Were the NHI to relocate queues from public sector health establishments in townships to NHI contracted doctors' rooms in the suburbs, it is likely that a similar system would evolve in the latter to reabsorb nurses from the public sector, and to economize on scarce and relatively expensive GP time.

The NHIB aims to absorb private health care providers. If Section 12(1) remains, users have to receive health services covered by the NHI Fund from certificated and accredited service providers at no cost. This means that health care providers wishing to offer such services will have no choice but to seek a contract with the Fund. These providers will then be subject to the conditions of the Fund relating to pricing and provision of services. Coercion of users implies coercion of health care providers, and resistance by providers can be expected, with an accompanying risk of withdrawal of services altogether. The HSF opposes coercion of providers, just as it opposes coercion of users. As the WHO suggests, private practitioners should rather be incentivised to contract.

Is there excess capacity in the private health sector, in the form of inefficient use of health care providers and health establishments? The Competition Commission's Health Market Inquiry's provisional report concludes that there is, especially in the use of hospital beds. The report advocates a range of measures designed to regulate private health care markets in order to remedy market failures and reduce costs to users. The HSF supports measures that will make private health care markets more competitive, and notes that National Health Insurance is not needed for this purpose. We also note that the public sector is already empowered to negotiate contracts with private service providers, and mobilise private excess capacity in this manner.

6.3 Governance

The NHIB invests the Minister of Health with wide-ranging powers. Section 14(1) provides that members of the NHI Fund Board are to be appointed by Cabinet, on the advice of the Minister. Section 14(3) states that an ad hoc Cabinet committee must conduct public interviews of short listed candidates and forward their recommendations to the Minister for approval. Presumably, the Minister's list would constitute his advice to Cabinet. The NHI Fund Board must conduct interviews

[11] WHO Definition of heath financing.

of short listed candidates for the post of Chief Executive Officer and forward its recommendations to the Minister, who makes the appointment. The Minister appoints the Benefit Advisory Committee under Section 25(2), the chair and deputy chair of the Health Benefits Pricing Committee under Section 26(3), and may establish a Stakeholder Advisory Committee under Section 27(1). Some members of the Committees will be ex officio and some will be nominated by various constituencies. The Minister may also appoint technical committees to achieve the objectives of the NHIB under Section 28(1) of the Act.

Section 40 provides that an affected user, service provider, health establishment or a supplier may lodge a complaint with the Fund about its procedures. Such a complaint has to be investigated and recommendations forwarded to the Chief Executive Officer. Section 41 provides that, should the aggrieved party not be satisfied with the Fund's response, it can lodge an appeal with an Appeal Tribunal, whose members, in terms of Section 42(1), are appointed by the Minister. Section 45(4) states that nothing precludes a party aggrieved by the Appeal Tribunal from seeking suitable redress in a court of law that has jurisdiction to hear such a matter. Section 25(5), which deals with the removal of the Chief Executive Officer of the Fund, is the only reference to removal in the NHIB. It empowers the Fund Board to recommend the removal of the CEO to the Minister under specified circumstances, implying that the Minister makes the decision.

Our view is that the NHI governance structure contains too little in the way of the checks and balances necessary for enforcing rational decision making. All discretionary appointments throughout the managerial structure of the NHI are appointed by a single individual, or heavily influenced by him or her in the case of the Fund Board. The NHI Fund proposes to act as a gatekeeper, receiving all funding and distributing it as it determines. The Fund will also be in a position of power as regards to accreditation of health care providers and health establishments.

The HSF strongly supports governance structures that promote, indeed require, rational decision making. In particular we are concerned about appointment processes, removal processes and review of decisions. We have litigated several times about exactly these issues in different contexts, and court judgments have emphasised the importance of independence, transparency and review as means of enforcing rationality. Failure to incorporate these features to the full in the health system runs the risk of legal contestation in this field also.

6.4 The District Health System

Primary health care is the responsibility of district health facilities. Currently, district health services struggle to meet this mandate. The South African Health Review lists specific institutional design blockages which result in inefficiencies:

> District management has no influence over policy directives; strategy is designed at national and provincial level; district management has limited influence over national budget; district management does not control workforce planning and appointment of staff; no clear system whereby lessons learnt at district level are used to influence policy or strategy; senior management fail to modify

policy to fit the reality on the ground; management do not consistently and effectively use data for evidence-based decision making.[12]

The NHIB does not seek to deal with these issues. The NHIB **a**ffects district health services only by imposing a need for accreditation and by changing the way in which they are funded. As things stand, most clinics would not meet the accreditation criteria. The NHIB's specification of the funding mechanism is sketchy. Section 26(4) requires the Health Benefits Pricing Committee, established under Section 26(1) to recommend the prices of health service benefits to the Fund. Section 5(1)(f) requires the NHI Fund to determine prices annually after consultation with health care providers, health establishments and suppliers. Section 10(1) requires the NHI Fund to reimburse health care providers for health service benefits rendered to the eligible users.

Moreover, the NHIB in conjunction with the NHA creates confusion. Section 31 of the NHA establishes District Health Councils as joint ventures between provinces and individual metropolitan or district municipalities. These Councils co-ordinate planning, budgeting, provisioning and monitoring of all health services that affect residents, and advise provincial and metropolitan or district authorities on health matters. Section 36(1) of the NHIB refers to District Health Management Offices established by section 31A of the National Health Act. Section 31A of the NHA does not exist currently, but the NHIB intends to insert it. These Offices are expected to facilitate, coordinate and manage the provision of non-personal public health care programmes at district level in compliance with national policy guidelines and applicable law. Non-personal public health care programmes are not defined within the NHIB, and it is difficult to see what are included in them. And, in any event, the reimbursed services provided by district health facilities will be determined by the NHI Fund, advised by the Benefits Advisory Committee established by Section 25 of the NHIB**.** Not just one, but two institutions seem excessive under the circumstances.

In short, none of the systemic failures crippling the district health system are addressed by the NHIB.

6.5 Conclusion

Our general assessment of the NHIB is as follows:

i) It seeks to establish a set of NHI institutions and procedures, without any accompanying account of NHI benefits and costs. To quote the Minister again:

> NHI is not a Rolls Royce, but it's not a Toyota – it is what South Africans will design it to be[13]

South Africans are being asked to support a process whose outcome is subject to radical uncertainty.

[12] SAHR 2017
[13] Lameez Omerjee, op.cit.

ii) It is driven by a long-standing government belief that the particular form of financing mechanisms specified in the NHIB are the key to fixing the health system. They are not, and the result is that the NHIB floats above the issues facing the public and private health systems on the ground.

iii) We do not believe that the South African state has the capacity to manage a very complex single-payer NHI system. Incompetence and corruption are now endemic in South African public administration, and the NHI Fund will become a very large honey pot.

iv) In the light of the managerial challenges in the existing public health establishments, we think the extensive addition to the managerial burden implicit in the NHI will worsen performance rather than improve it.

v) The NHIB seeks to coerce users and health care providers alike, and resistance from both constituencies can be expected.

vi) In economic terms, health care is a private good[14] by its nature, and no moral or political decision, or chatter about 'commodification', can change the situation[15]. A private good can only be distributed equally by an army quartermaster system. That is clearly the underlying principle for services provided by the NHI Fund. Standard treatment protocols, referral systems and no payment at the point of service are all designed to produce equality of treatment. But there will continue to be a second tier of services which can be covered by out of pocket payments or medical aids. The relative sizes of the tiers will depend on the size of the NHI Fund budget, and we believe that fiscal constraints mean that the second tier would be large for the foreseeable future. Moreover, unless Section 12(1) of the NHI Bill is read restrictively[16], people will continue to be able to purchase NHI services in the second tier if they pay out of pocket.

In short, the NHIB does not abolish a tiered health system. It merely redefines the boundary between tiers. It follows that equality throughout the health system as a whole is not possible, and the claim that the NHI can make it equal is wrong. These observations do not preclude moral argument about health services, but they do impose some limits on it. The HSF believes that the aim should be to raise the platform below which no-one can fall to the highest possible level, a point we return to in Section 8 below.

[14] A private good has two characteristics: (1) it is rival in consumption (the particular health care service which A consumes cannot be consumed by B. B may get the same treatment as A, but with the use of different resources, e.g. a separate consultation with a GP) and (2) it is excludable (people may be excluded from receiving health care of a specific type, e.g. dialysis for the over 50s in the public sector, and they may be excluded from receiving care by a private provider, eg. If they are unable to afford the fee).

[15] True, there are spill over effects, for example, if A's inoculation against an infectious diseases reduces B's change of getting it, and this is a case for government subsidised inoculation campaigns.

[16] See the discussion in Section 6.1 above

7. The Medical Schemes Amendment Bill

The MSAB has to be considered in relation to:

1) National Health Insurance
2) The Act it seeks to amend
3) The Competition Commission's Health Market Inquiry findings and recommendations report.

Since we believe that the NHIB should be withdrawn, all sections of the MSAB dealing with National Health Insurance should be deleted.

Our ability to comment on other issues is hampered by the lack of an explanatory memorandum accompanying the MSAB. Nonetheless, the HSF supports, in principle, some changes proposed in the Amendment Bill that are both necessary for private health care regulation and that seek to rectify structural problems within the sector.

First, the Bill expands Section 56 of the MSA to include provisions that seek to establish stronger corporate governance structures in medical schemes. It sets out the composition of boards of trustees, clarifies their duties, establishes procedures for the appointment and removal of the Chief Executive Officer, clarifies his or her duties, and sets out the requirements to determine fitness to hold office. Sound corporate governance structures are essential for ensuring that medical schemes are managed in the best interests of their members.

Secondly, by amending Sections 47 to 50 of the MSA, the Bill establishes a procedure by which a complaint about a medical scheme must first be considered by the scheme with a view to finding a solution. Should the complainant remain unsatisfied, the complaint may be taken to the Registrar of Medical Schemes for decision. Parties aggrieved by the Registrar's decision may appeal it to an Appeal Board, appointed by the Minister and provides a detailed procedure for appealing against a decision taken by the Registrar of medical schemes. The decision of the Appeal Board is final and binding, subject to the decision of a court in judicial review proceedings under the Promotion of Administrative Justice Act.

Thirdly, Section 32B(2) is inserted into the MSA, proscribing imposing any waiting period on children and requiring medical schemes to enrol, admit or recognise any child as a dependent upon receipt of an application by a member.

However, we are concerned about three aspects of the MSAB.

First, the MSAB amends the MSA by inserting Section 32F(2), which specifies that the contribution in respect of a child beneficiary may not exceed 20 per cent of the contribution in respect of an adult beneficiary and the contribution of a young adult (between the ages of 18 and 30) may not exceed 40 per cent of the contribution of an older adult. The problems are twofold. The rationale for a lower rate for young adults is not clear, especially in the light of desirability of cross-subsidisation of those in poor health by those in good health. Secondly, it is not clear what the effect of these

provisions will be on contributions by older adults. Indeed, the effect will vary from scheme to scheme, depending on their current contributions. But the general tendency will be to push older adult contributions up, sometimes sharply.

Secondly, Section 2 of the MSAB excludes the application of the Consumer Protection Act ("**CPA**") from matters relating to the MSA. The MSA and its regulations, even if the changes from the Amendment Act are effected, are not comprehensive enough to cover members with the protection provided by the CPA. There remains a whole host of rights included in the CPA that are not covered, or as extensively, in the MSA. It is unclear why the MSAB specifically seeks to exclude the application of the CPA.

Thirdly, while the waiting period for children disappears under the MSAB, the MSAB also removes current limitations on waiting periods for adults.

Although the findings and recommendations of the Health Market Inquiry are provisional at this stage, and although we believe that the MSAB should not be processed until the Inquiry report is finalised, we note that the provisional report provides some insight into the structural failures of the private health care sector that relate to and influence medical schemes. The provisional findings conclude that "there has been a lack of attention to the regulatory framework of the private healthcare sector." The partial regulatory framework has led to an ineffective Prescribed Minimum Benefits ("**PMB**") environment and risk pooling fragmentation and failures that contribute to escalating costs in the private health care sector.

The Inquiry's preliminary report also sets out weaknesses in the governance structures of medical schemes, particularly in relation to trustee independence, transparency measures, effective oversight of administrators by trustees and effective regulatory enforcement and oversight of medical schemes by the Council of Medical Schemes. The MSAB has proposed considerable changes to the governance structure of medical schemes that address some concerns raised in the Inquiry's report, and the HSF supports them.

However, the HSF remains concerned about the role of medical schemes in relation to third parties like administrators and managed care organisations.

Administrators, as profit-making entities, in particular, have a strong influence over the medical schemes that contract them. The MSAB has included an expressed provision for the duty of care placed on trustees and chief executive officers toward the interests of their members. This duty encompasses four things: (i) to take all reasonable steps to ensure that members' interests are protected at all times; (ii) to act in good faith and exercise due care and diligence in the performance of their powers, duties and functions; (iii) to take all reasonable steps to avoid conflicts of interest; and (iv) to act impartially and objectively in relation to all members. While these duties may express the level of care necessary to provide some form of protection for members' interests in the relationship between medical schemes and their administrators, they are far too broad to change the relationship dynamics within the current scheme-administrator relationship.

8. Our preferred alternative

The HSF's approach to health care system development is that it should consist of initiatives to take care of unmet need by radical improvement of the public health sector, rather than the extensive change in health care finance proposed by the NHI. In taking this approach, we support useful public sector developments. For instance, the personal services component of the National Health Insurance Indirect Grant[17] includes: expanding access to school health services, focusing on optometry and audiology; contracting general practitioners by capitation, that is, paying care providers a set annual amount per patient registered in their practice instead of fees per service provided; and providing community mental health services, maternal care for high risk pregnancies, screening and treatment for breast and cervical cancer, hip and knee arthroplasty, cataract surgeries, and wheelchairs[18]. More extensive provision of dentistry could also be added.

We also support the use of ward-based primary health care outreach teams, and welcome the allocation of funds to standardise and strengthen the training, service package, and performance monitoring of community health workers[19]. Both the National Income Dynamics Survey in 2014/15 and the General Household Survey in 2015 indicate that treatment rates are high for the diseases about which information was collected[20]. However, a recent study of TB care[21] is cause for concern. It estimated that the overall tuberculosis burden was 532 000 cases, with successful completion of treatment in 53% of cases. Losses occurred at multiple steps: 5% at test access, 13% at diagnosis, 12% at treatment initiation, and 17% at successful treatment completion. The 13% of cases lost between tuberculosis testing and diagnosis, were partly as a result of the failure to comply with diagnostic algorithms. The 12% of cases diagnosed but not treated reflected fragmented data systems between laboratories and health facilities, poor recording of patients' contact details, results not being available when patients return to the health facilities and poor follow-up of patients who do not return for test results.

TB apart, the main problems are twofold: the extent to which people who have a disease are not diagnosed, and the efficacy of treatment. Community health workers can play an important role in referring the sick to the health care system, and conducting simple tests, such as blood pressure measurement and identification of obvious sight and mobility problems, during home visits. Treatment efficiency issues can be identified by studies of the effects of treatment protocols.

In light of our particularly low global ranking when it comes to mortality risk among adults between the ages of 30 and 70, and the prominence of non-communicable diseases as a cause of years lost to disability, we also believe that more resources need to be devoted to them. We have been alarmed

[17] The name of this grant is misleading, as it is allocated to the existing public health system, but no matter.
[18] National Treasury, 2018 Budget, Estimates of National Expenditure, p 311
[19] National Treasury, op cit, p312
[20] Appendix, Table 2
[21] Pren Naidoo et al. The South African Tuberculosis Care Cascade: Estimated Losses and Methodological Challenges, *The Journal of Infectious Diseases*, Volume 216, Issue supplement 7, 6 November 2017, Pages S702–S713

at recent reports of the status of oncology in the public health system[22]. The burden of HIV and TB have crowded out attention to non-communicable diseases, but disability adjusted life years lost (DALYs) as a result of non-communicable diseases were almost as great as those lost to communicable, maternal, perinatal and nutritional conditions in 2016[23]. The top five non-communicable categories by DALYs were cardiovascular conditions, malignant neoplasms (cancer), diabetes mellitus, mental illness and substance abuse, and non-communicable respiratory disease.

We believe that the formation of an Office of Health Standards Compliance has been useful, and that it should be allocated the resources to inspect every clinic and hospital once every five years, with follow up as appropriate. As indicated above, we would welcome the publication of a report on Phase 1 of NHI and other assessments of the functioning of the public health system.

9. Conclusion

We summarize our views as follows:

1. The public health system is certainly under pressure and we support both sustained attention to managerial issues within it, and allocation of more resources to it in order to improve current services and to introduce new ones to deal with unmet need. The problem is that the health care system has to compete with other demands for public expenditure in the context of low economic growth and fiscal constraint.
2. However, we do not support the introduction of national health insurance as a solution to the problem, for the reasons outlined in Section 6.5 of this submission. Moreover, the funds allocated to the introduction of national health insurance in the 2018 Budget and Medium Term Expenditure Framework are tiny in relation to aggregate health expenditure. Should the government continue along the course set out in the NHIB, it will come to a point when a massive transfer into the NHI Fund will be required, with no means for financing it.
3. To the extent that more redistributive policies are desired by the government to finance health expenditure and other social expenditures, currently available fiscal instruments can be used to meet them. An NHI system is not needed to meet distributive goals.
4. We support regulatory changes needed to make medical schemes more efficient and to play a role in making the private health sector more efficient. We believe that the provisional report of the Competition Commission's Health Care Inquiry makes a number of useful recommendations in this respect. We believe that the MSAB should be reconsidered when the final Inquiry report becomes available and that all references to NHI should be excised from it.

[22] See, for instance, Health-e News, Cancer treatment in the public sector is 'in crisis', Daily Maverick, 25 June 2017, and Medical Brief, Cancer services failing throughout SA, 6 June 2018

[23] WHO, Global Health Estimates 2016 Summary Tables, June 2018. Also see Appendix Table 3

19 September 2018

Agathe Fonkam
Intern

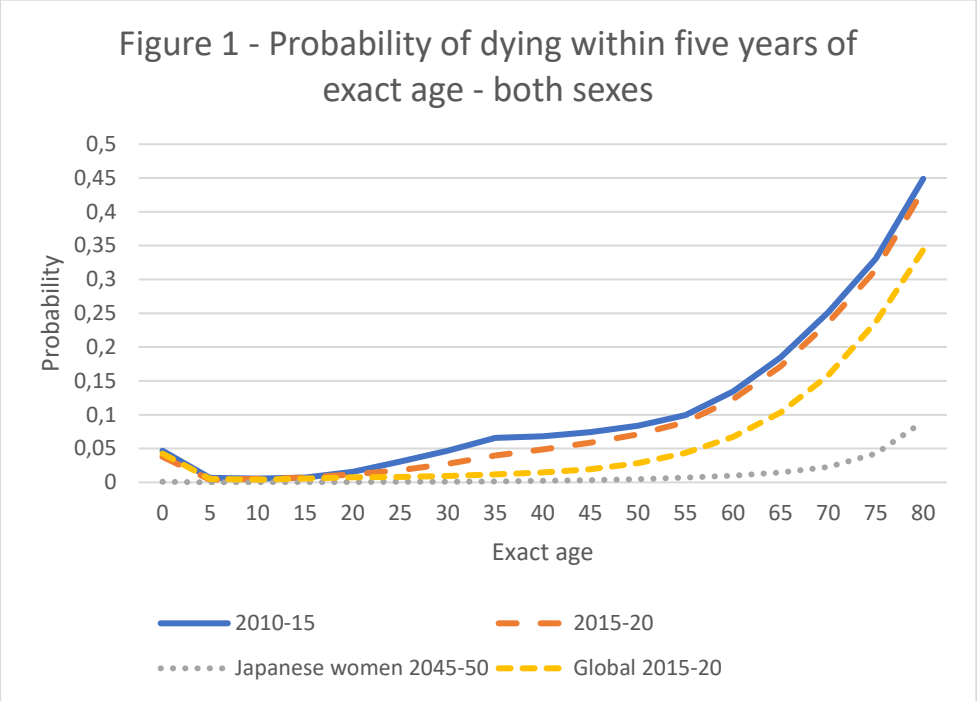
Michelle Toxopeus
Legal Researcher

PJ Hamilton
Legal Researcher

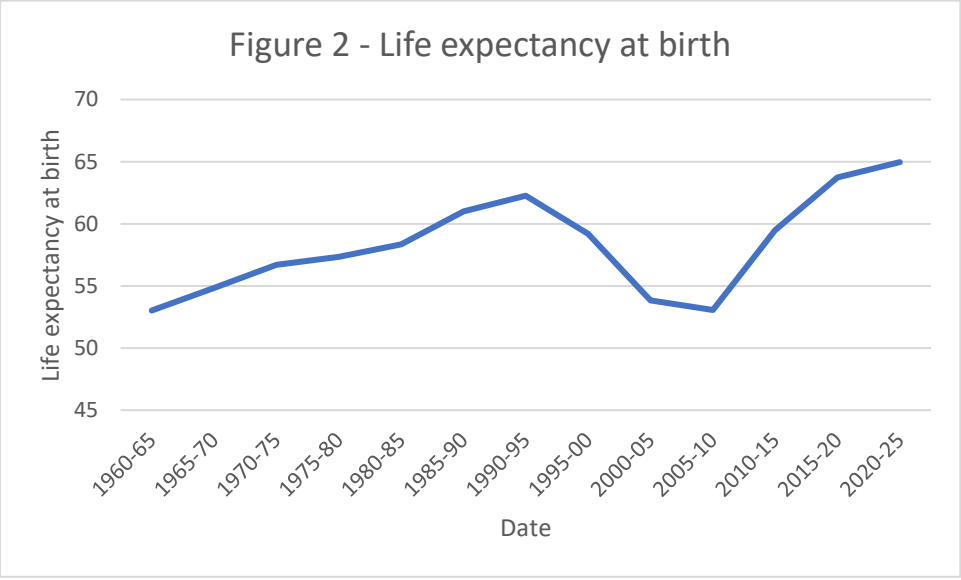
Charles Simkins
Head of Research

Francis Antonie
Director

Appendix – Health status indicators



Source: United Nations, World Population Prospects: 2017 revision, Abridged life tables, both sexes. Historical estimates and medium projections

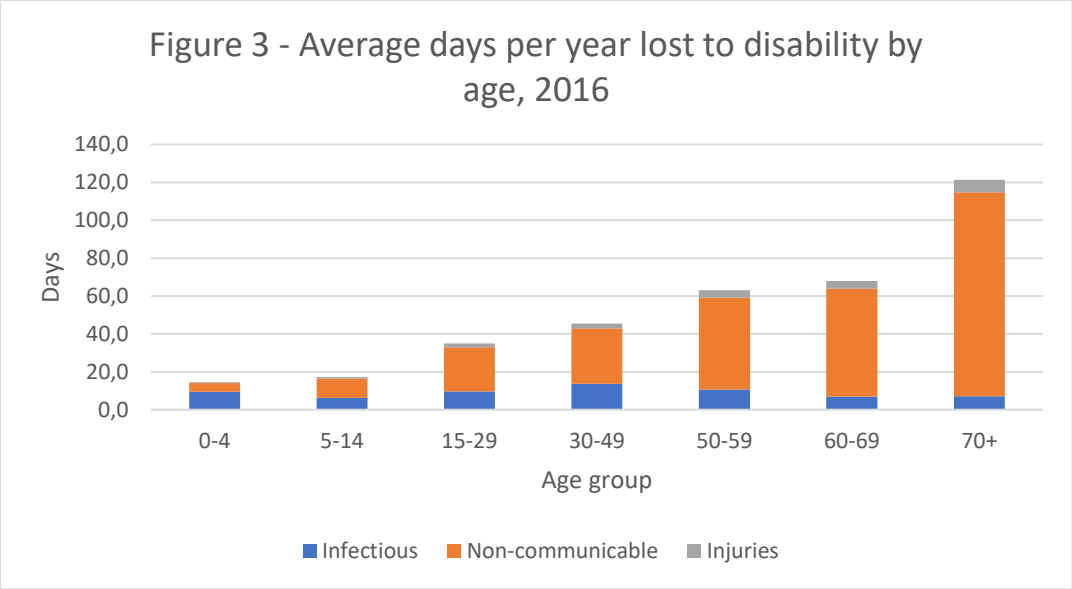


Source: United Nations, World Population Prospects: 2017 revision, Life expectancy at birth. Historical estimates and medium projections

Table 1 - South Africa's global rankings, 2015

GDP per capita (PPP$)	93
Life expectancy at birth	175
Probability of dying before age 5	144
Probability that a person alive at age 5 will die before age 30	166
Probability that a person alive at age 30 will die before age 70	194

Sources: GDP per capita: World Bank data
Mortality risk: World Population projections 2017 revision, Abridged life tables, both sexes.



Source: WHO, Years lost to disability, 2016 estimates

Table 2 - Treatment rates among the ever diagnosed

Disease	National Income Dynamics Survey	General Household Survey	
	Age 15+	Age 15+	Age below 15
TB	71%	84%	87%
Hypertension	94%	96%	98%
Diabetes/high blood sugar	93%	96%	100%
Mental illness		97%	90%
Asthma	76%	88%	87%
Heart disease	79%	76%	85%
High cholesterol		92%	100%
Osteoporosis		86%	

Table 3 - Disability-adjusted years of life lost, 2016
Thousands

Communicable, maternal, perinatal and nutritional conditions	12795
Non-communicable	11850
Of which	
Cardiovascular	*2482*
Malignant neoplasms	*1633*
Diabetes mellitus	*1224*
Mental illness and substance abuse	*1219*
Non-communicable respiratory	*836*
Injuries	2936
Total	27581