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Submission to the National Department of Health

National Health Insurance White Paper

Submitted by the Free Market Foundation

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FREE MARKET FOUNDATION

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About the Free Market Foundation

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

Most of the work of the FMF is devoted to promoting economic freedom as the empirically best policy for bringing about economic growth, wealth creation, employment, poverty reduction, and human welfare. As a think-tank, the FMF's fundamental approach to policy questions is consumer-based. Individual consumer choice is placed at the centre of any policy recommendations that the FMF espouses. Consumer satisfaction is generally achieved by an absence of barriers to entry into the provision of goods and services, allowing consumers a choice between the offerings of freely competing providers, and the absence of regulations that impose avoidable costly burdens on the providers of goods and services.

Introductory Comments and Opening Remarks

The National Department of Health (NDOH) published its latest policy proposals on the planned National Health Insurance (NHI) in the *Government Gazette* on 10 December 2015 (the White Paper) and interested persons were invited to submit comments and representations on the White Paper policy proposal. The FMF welcomes the opportunity to participate and provide input in this critical debate.

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

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

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

Thomas Sowell

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

The proposed National Health Insurance will:

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

At the outset, we wish to voice our concern that despite 40 different versions and more than four years having elapsed since the publication of the Green Paper on NHI, South Africans are no closer to understanding any of the material details of the proposed NHI including, but not limited to: how much the proposed scheme will cost, where the funding to finance the scheme will come from, and where we will obtain the additional personnel (both medical and bureaucratic) to staff the ambitious proposal. Yet government appears to be going ahead with the NHI scheme, and, in fact, is now entering the second phase of implementation of the project. We are concerned, given the conspicuous absence of the material details underlying the proposed scheme, that this is a politically motivated

event that will not materially improve the health outcomes of the poorest and most vulnerable members of society and may actually do more harm than good.

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

Professors Servaas van der Berg and Heather McLeod

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

National Health Insurance for South Africa

The opening sentence of the White Paper states, "National Health Insurance (NHI) is a health financing system that is designed to pool funds to provide access to quality, affordable personal health services for all South Africans based on their health needs, irrespective of their socioeconomic status". It is not clear how the White Paper defines "affordable" when, in the same sentence, the White Paper suggests that patients will be provided with care "irrespective of their socio-economic status". This seems to imply that the White Paper defines affordable as "free". Attempting to provide "free" healthcare for all at the point of service is not a particularly good use of scarce taxpayer resources since each additional rand committed to healthcare expenditure necessarily comes at the expense of funding for other objectives, which may be more efficiently utilised at the margin.

Advanced, developed countries are struggling to meet the healthcare demands of their citizens under their "free healthcare for all" systems. Indeed, ample evidence exists of how government involvement in healthcare increases costs, erodes quality, and thwarts innovation. For example, a 2015 study entitled: *Waiting Your Turn – Wait times for health care in Canada* by the Fraser Institute found that wait times for medically necessary treatment in Canada have increased from 9.3 weeks in 1993 to 18.3 weeks in 2015. Especially long wait times were experienced for orthopedic surgery (35.7 weeks) and neurosurgery (27.6 weeks).[2]

The estimated cost of waiting for care in Canada for patients who were in the queue in 2015, according to calculations based on the methodology produced by Globerman and Hoye (1990), was almost CAD1.2 billion[3] (approximately R14.5 billion) – an average of about CAD1,304 (R15,752) for each of the estimated 894,449 Canadians waiting for treatment in 2015. Alternatively, that cost works out to roughly CAD12,280 (R148,342) for each individual among the 11.0 percent of patients in the queue who were suffering considerable hardship while waiting for care. Moreover, this estimate only counts costs that are borne by the individual waiting for treatment. The costs of care provided by family members (in time spent caring for the individual waiting for treatment) and their lost productivity due to difficulty or mental anguish, are not valued in this estimate.[4]

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

Many Canadian trained and previously active physicians have left Canada for better opportunities and working conditions in the United States. In contrast, American doctors are not voting with their feet by moving to Canada for better opportunities or working conditions. According to the Fraser Institute, as of 2002, there were 8,990 Canadian-trained physicians (a number equal to 13 percent of the Canadian physician workforce) actively practising in the United States. By contrast, only 519 American-

[2] Fraser Institute (2015) Waiting Your Turn – Wait times for health care in Canada. Available at: https://www.fraserinstitute.org/sites/default/files/waiting-your-turn-2015.pdf

[3] CAD = Canadian Dollars. A the time of writing CAD1 = R12.08

[4] Fraser Institute (2016) The Private Cost of Public Queues for Medically Necessary Care, 2016 edition. Available at: https://www.fraserinstitute.org/sites/default/files/private-cost-of-public-queues-for-medically-necessary-care-2016.pdf

trained physicians (equal to less than 1 percent of the American physician workforce) were working in Canada.[5]

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

According to the Fraser Institute, "Canadians do not get good value for money from their health system. There are many hidden costs in Canadian health care that are ignored by advocates of single-payer systems. On a comparable basis, Canadians have fewer doctors and less high-tech equipment than Americans. Canadians also have older hospitals and have access to fewer advanced medicines than Americans… If Canadians had access to the same quality and quantity of health care resources that American patients enjoy, the government health insurance monopoly in Canada would cost a lot more than it currently does. Not only do Canadians have fewer health care resources than Americans, experience also shows that the Canadian health system is not financially sustainable in the long run".[6]

Canada is not the only advanced country that is struggling to meet the healthcare demands of its citizens. The British National Health Service (NHS) is often held up as an example of egalitarian healthcare, funded through general taxation and free at the point of use. However, it has demonstrated all the flaws that might be expected from a state monopoly: waste, inefficiency, under-investment, rationing and constant political interference. The result has been poor health outcomes for British citizens compared with other wealthy countries, and a failure by the NHS to live up to its founding principles of comprehensive, unlimited healthcare and egalitarianism. Indeed, recent headlines in *The Guardian* stated, "[Britain's] NHS is in trouble and its chief executive has requested £8bn to save it".[7] Moreover, *The Guardian* states, in the NHS's efforts to cut costs "the savings have been accompanied by a substantial decline in quality – as revealed by treatment waiting time targets…there is growing evidence that, even in the parts of the country supposed to be leading the way, there are often insurmountable difficulties in trying to change the way NHS works".[8] *The Guardian* goes on to note that, "A big part of the problem is that the central bodies have provided virtually no support in clearing obstructions out of the way nationally to enable local changes to take place… Everyone agrees what needs to change, the central bodies are far too slow in enabling change to happen, the case for change becomes ever more urgent as finances deteriorate, then that deterioration forces ever greater focus on short-term cash savings rather than long-term transformation of care".[9]

In order to correct the problems associated with government-run national health systems; the British NHS system is adopting a number of reforms where the private sector will play an increasing role in both financing and delivery of health care. In her paper entitled "NHS as State Failure: Lessons from

[5] Fraser Institute (2008) The Hidden Costs of Single Payer Health Insurance. Available at: https://www.fraserinstitute.org/sites/default/files/HiddenCostsSinglePayer.pdf
[6] ibid
[7] http://www.theguardian.com/society/2014/oct/29/how-sick-are-worlds-healthcare-systems-nhs-china-india-us-germany
[8] http://www.theguardian.com/healthcare-network/2016/may/13/the-nhs-cannot-escape-its-financial-crisis-without-more-money
[9] http://www.theguardian.com/healthcare-network/2016/may/13/the-nhs-cannot-escape-its-financial-crisis-without-more-money

the Reality of Nationalised Health Care", published in the December 2008 issue of *Economic Affairs*, Helen Evans, the Director of Nurses for Reform in the UK, notes, "Under the general rubric of Public Private Partnerships, the British government has championed a whole raft of market-oriented reforms".[10]

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

In a welcome change to past legislation, seriously ill patients are now allowed to add their own money to the purchase of the most innovative medicines and treatments. Evans (2008) states, "Only by putting patients and consumers' interests first will healthcare really improve. It is only when healthcare is opened up to real consumers, trusted brands and new funding mechanisms – such as private health savings accounts – that nurses and other health professionals will find themselves working in environments with the incentives, resources and freedom to deliver responsive, popular and high quality care".[11] Evans concludes her paper by stating, "As such, I reject egalitarianism and nationalisation in favour of healthy privatisation and competition. Ultimately, 20 years working in the NHS has taught me to believe in people and markets – not political diktat".[12]

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

Constitutional mandate

The White Paper states, "NHI implementation is consistent with the Constitutional commitment for the state to take reasonable legislative and other measures, within its available resources, to achieve the progressive realisation of the right to have access to health care services including reproductive health care".[13] The FMF supports the notion of Universal Health Coverage (UHC) and agrees that all South Africans should have some form of health insurance. However, we question the validity of government attempting to provide "free healthcare for all". A better aim would be to determine the best way to increase access to quality healthcare for the poor. More specifically, we believe that government should use the same framework that it applies to other constitutionally mandated

[10] Evans, H. (2008) NHS as State Failure: Lessons from the Reality of Nationalised Healthcare. Restricted access available at: http://onlinelibrary.wiley.com/doi/10.1111/j.1468-0270.2008.00870.x/abstract
[11] ibid
[12] ibid
[13] Paragraph 3

objectives such as housing and education, where the state cares for the indigent and leaves the voluntary private market alone. To minimise the state's responsibility, the private sector should be deregulated while government concentrates on using scarce taxpayer resources to pay the premiums for the poor, rather than trying to insure the entire nation.

The White Paper states, "…Progressively realising this right will contribute to a healthy population that benefits the entire nation. NHI is a policy shift that will contribute towards poverty reduction and addressing the inequalities inherited from the past".[14] Setting aside the idea that UHC can only be achieved through a government controlled system of National Health Insurance, we query the implied assumption that health precedes wealth. In fact, the bulk of the academic literature suggests that causation runs in the opposite direction. For example, this relationship was confirmed by a seminal 1996 study by economists Lant Pritchett and Lawrence Summers, who showed the dramatic effect that increases in incomes can have on health. They found a strong causative effect of income on infant mortality and demonstrated that, if the developing world's growth rate had been 1.5 percentage points higher in the 1980s, half a million infant deaths would have been averted.[15]

It is intuitive that there is a strong relationship between income and health, not least because greater wealth buys greater access to the basic determinants of health such as nutrition, better accommodation and sanitation. The health of the world's population has been improving since modern economic growth began with the Industrial Revolution. Infant mortality and life expectancy rates have improved dramatically around the world, as increasing numbers of people abandon the precarious subsistence agrarian lives of their forebears and gain access to increasingly cheap food, better accommodation and sanitary infrastructure. Basic health indicators improved noticeably in rich countries from the mid- to late nineteenth century as nations cleaned-up their water supplies and instituted basic public health measures, such as sanitation, pasteurisation and vaccination. Indeed, in his submission to the Green Paper, Dr Gregory Ash states, "It is simply true that access to clean water, a good sewage system and education save far more lives that medicines ever do".

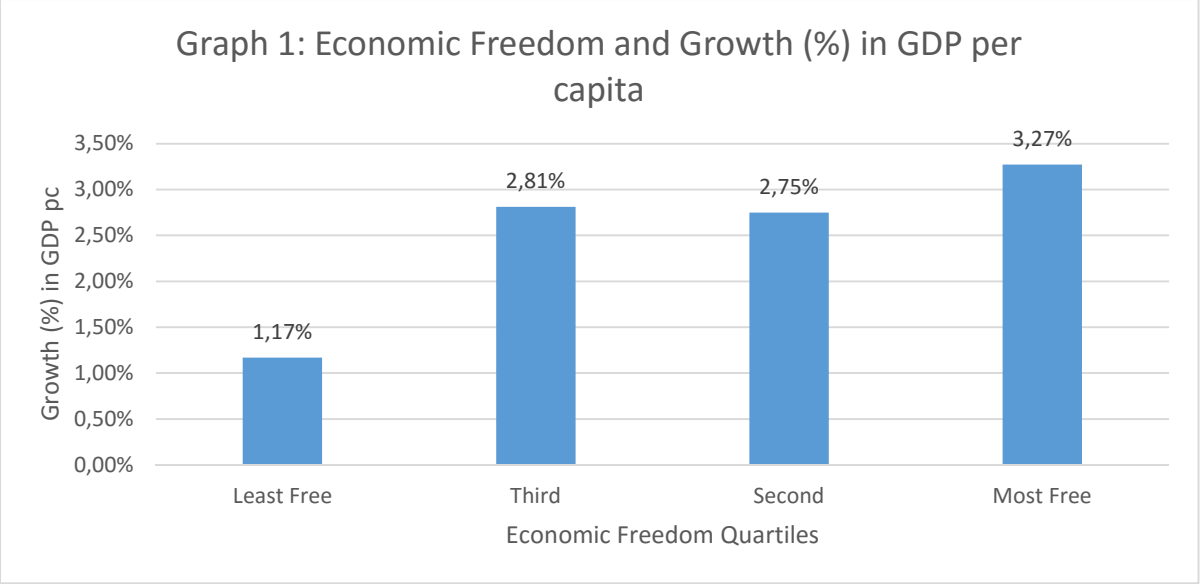
One of the surest ways to increase wealth in a country is to embark on economic reforms that result in higher levels of economic freedom. The foundations of economic freedom are personal choice, voluntary exchange, freedom to compete, and security of privately owned property. See for example, Fraser Institute's *Economic Freedom of the World*[16] and the Heritage Foundation's *Index of Economic Freedom*[17]. One of the key objectives in compiling these indices is to establish whether relationships exist between economic freedom and improved outcomes in terms of economic prosperity and improved health outcomes. The findings of the reports unambiguously support the fact that economic freedom is strongly related to prosperity and growth – countries that are economically free tend to grow faster and be more prosperous (see Graphs 1 and 2 respectively below). Moreover, life expectancy is almost twenty years longer in countries that enjoy greater levels of economic freedom than those with the lowest levels of economic freedom (see Graph 3 below).

[14] Paragraph 3

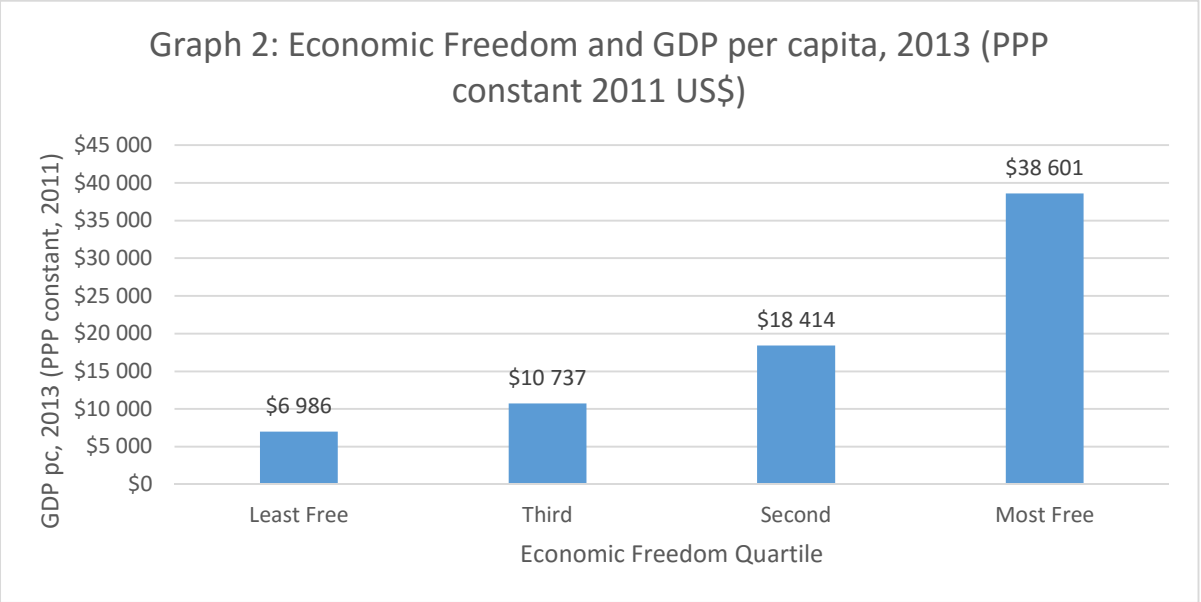
[15] Pritchett, L. and Lawrence H. Summers (1996) Wealthier is Healthier. The Journal of Human Resources, Vol. 31, No. 4, pp 841-868. Restricted access available at: https://www.jstor.org/stable/146149?seq=1#page_scan_tab_contents

[16] http://www.freetheworld.com/

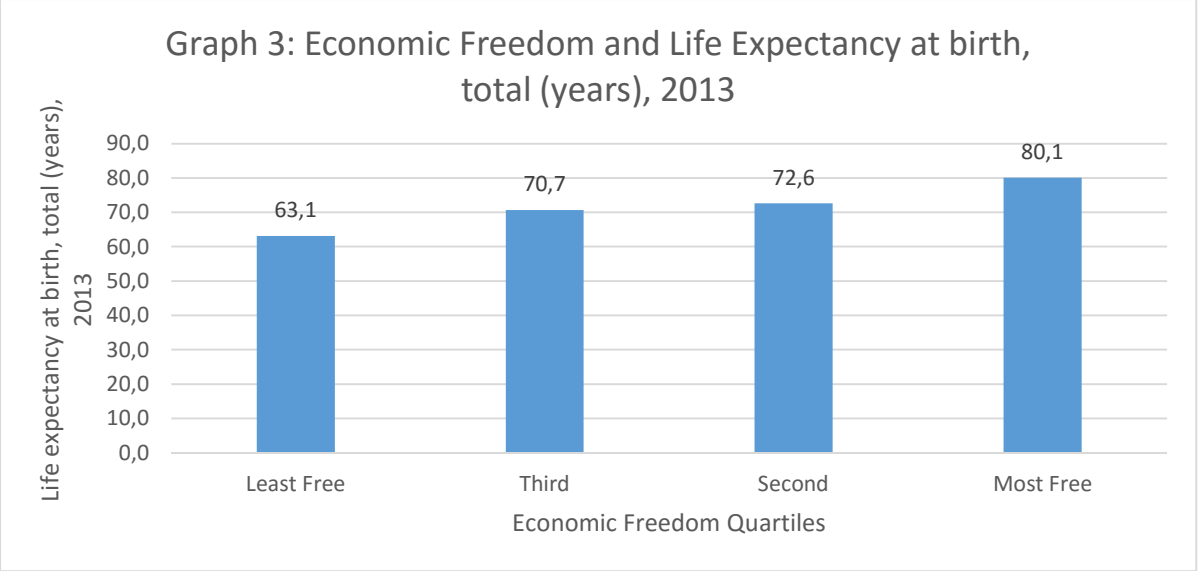
[17] http://www.heritage.org/index/



Source: Fraser Institute, Economic Freedom in the World (2015)



Source: Fraser Institute, Economic Freedom in the World (2015)



Source: Fraser Institute, Economic Freedom in the World (2015)

Without voluntary exchange and entrepreneurial activity coordinated through markets, modern living standards would be impossible. There is ample evidence to prove that economically free countries are wealthier and healthier than those that suppress their citizens' freedoms. The lesson here is: if South Africa wants to improve its health outcomes, it needs economic growth.

Before the government contemplates introducing a policy that requires a "massive reorganisation of the current healthcare system", perhaps it would be prudent to more carefully consider the country's economic circumstances. In addition to South Africa's dismal economic growth forecast of a meagre 0.6 percent for 2016, South Africa also suffers from the world's highest and most enduring unemployment problem. Indeed, South Africa's high and rising unemployment crisis has been a regular fixture since at least the mid-1970s, and introducing the proposed NHI before addressing the country's chronic unemployment situation "puts the cart before the horse".

Unemployment is South Africa's single biggest problem

The single biggest problem facing the country is chronic and persistent unemployment. According to Statistics South Africa (Stats SA), the official unemployment rate is currently 26.7 percent (1Q2016), which is the highest recorded unemployment rate since Stats SA began collecting unemployment statistics for the Quarterly Labour Force Survey. This means that over 5.7 million people are unemployed in South Africa.[18]

The strict definition of unemployment, however, is not a very good indicator of what is actually happening on the ground. The vast majority of unemployed people have simply given up searching for work – over two-thirds (66.9 percent) have been unemployed for more than a year. A better reflection of the unemployment situation in South Africa is called the expanded definition of unemployment and includes the so-called "discouraged work seekers". The expanded definition reveals that 36.3 percent of the working-aged population are unemployed, this equates to almost 9-million unemployed people.[19]

As a result of this massive unemployment problem, South Africa suffers from relatively low levels of incomes, and it should be noted that the twin evils of poverty and inequality are inextricably linked to unemployment. Yet, despite these and other glaring problems, including a dismal economic growth outlook which raises the issue of the very real possibility of a ratings downgrade that could necessitate an IMF bailout, the government has already begun to implement NHI.

[18] Statistics South Africa (2016) Quarterly Labour Force Survey, Quarter 1, 2016. Available at: http://www.statssa.gov.za/publications/P0211/P02111stQuarter2016.pdf
[19] ibid

Dispelling Myths

A number of myths have been circulated in order to provide "justification" for the introduction of the proposed NHI scheme. However, many of the purported justifications are simply strawmen or even worse, outright lies, that require dispelling if the very real underlying issues that are hampering access to quality health care for poor South Africans are to be addressed.

"Uncontrolled commercialisation"

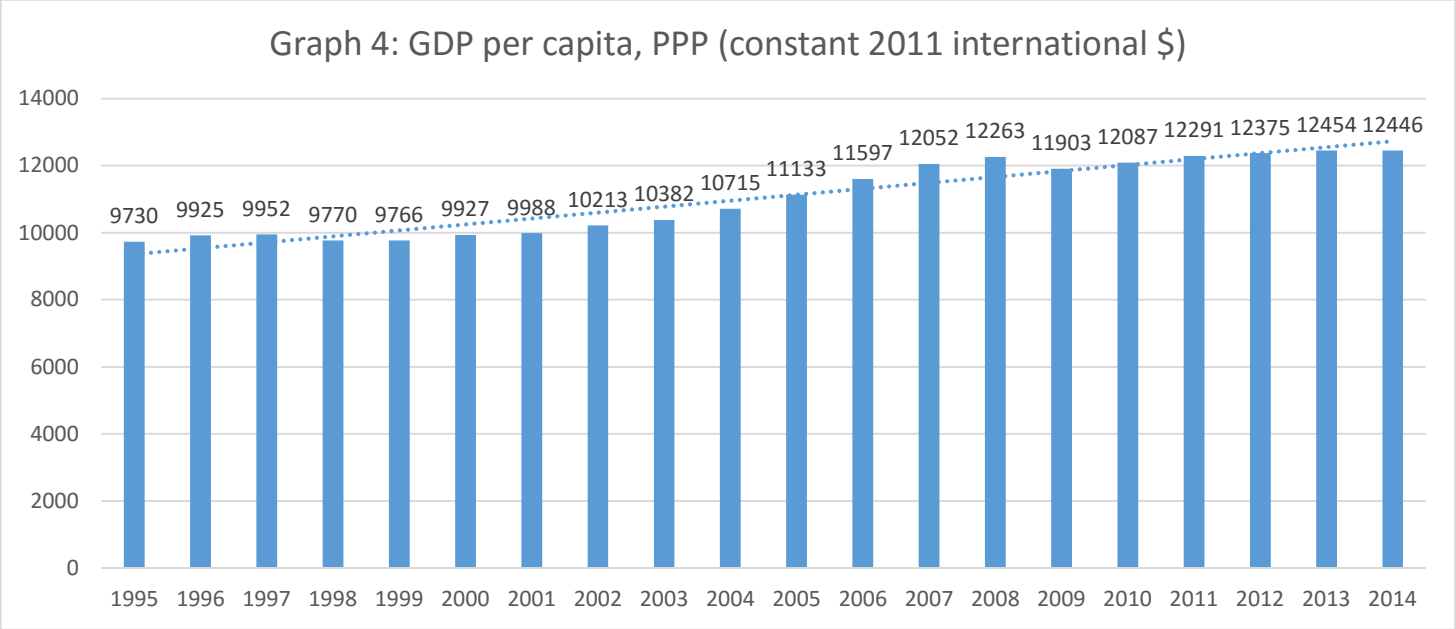
The current government is disturbed by the rapid growth of what it regards as "uncontrolled commercialisation" of private healthcare. But private healthcare in South Africa is already heavily regulated. Substantial market movements have occurred which display compliance with and the consequent effects of the regulations. Rising healthcare costs in South Africa are not peculiar and certainly not unique to the private healthcare sector.

All across the globe, governments are grappling with the question of how to contain healthcare costs. Since most governments dominate healthcare sectors, rising healthcare costs have become a "problem" because governments have relatively fixed budgets and increased spending in one area necessarily comes at the expense of other areas. For example, in the OECD countries, health expenditure as a percentage of GDP has risen steadily for several years to reach more than 12.3 percent in 2013. Most of the OECD countries have UHC through publicly financed health services. But this is not the only version of UHC. For example, Switzerland and the Netherlands have a universal mandatory private health insurance system, with regulated competition across multiple insurers. In Switzerland, the government subsidises premia in order to assist people to purchase mandatory health insurance from competing private insurers.[20] Mexico encourages the uninsured population to take up voluntary insurance by offering an improved package of services financed by a combination of individual premia and government subsidies to the poorest population groups.

Health care costs have increased due to a number of factors. Global incomes are rising at an unprecedented rate so people are demanding more and better healthcare services. This leads to greater healthcare expenditure since healthcare is what economists refer to as a "superior good" – when incomes go up, people not only consume more health care, they increase the percentage of their income that they are prepared to spend on health care.

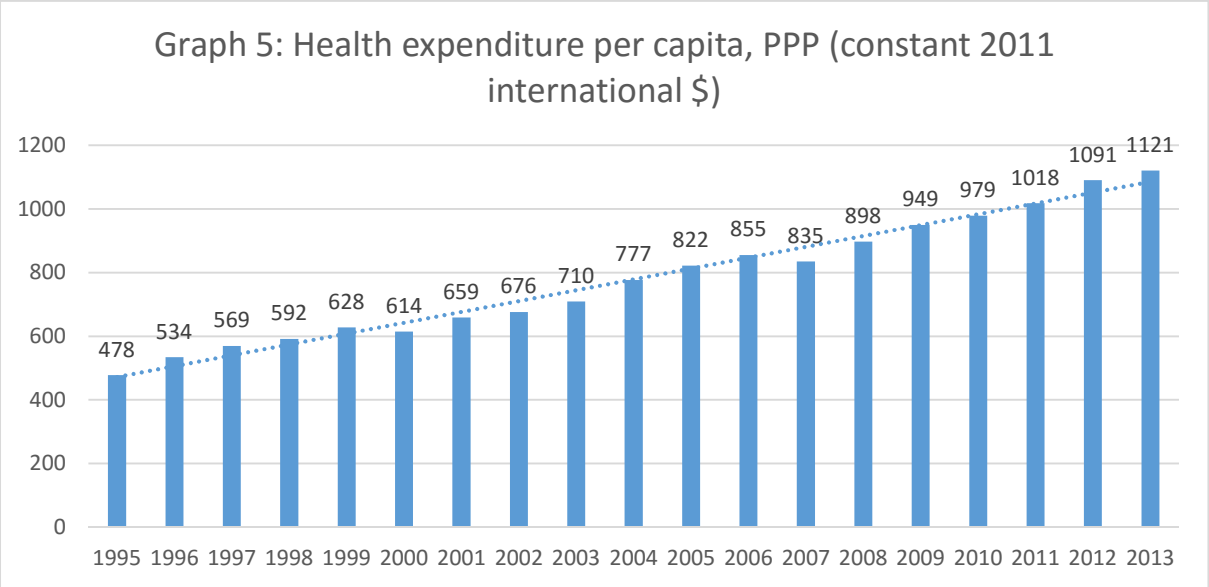
As can be seen from Graph 4 below, South Africans, too, are getting richer. Real GDP per capita (PPP-adjusted) increased from $9,730 in 1995 to $12,446 in 2014 (an increase of 28 percent). At the same time, real health expenditure per capita increased from $478 to $1,121 (an increase of 135 percent). As a proportion of income, real health expenditure per capita increased from 5 percent to 9 percent (see Graph 5 below).

[20] http://www.oecd.org/health/developingahealthcaresystembenefitingall.htm



Source: World Bank, World Development Indicators

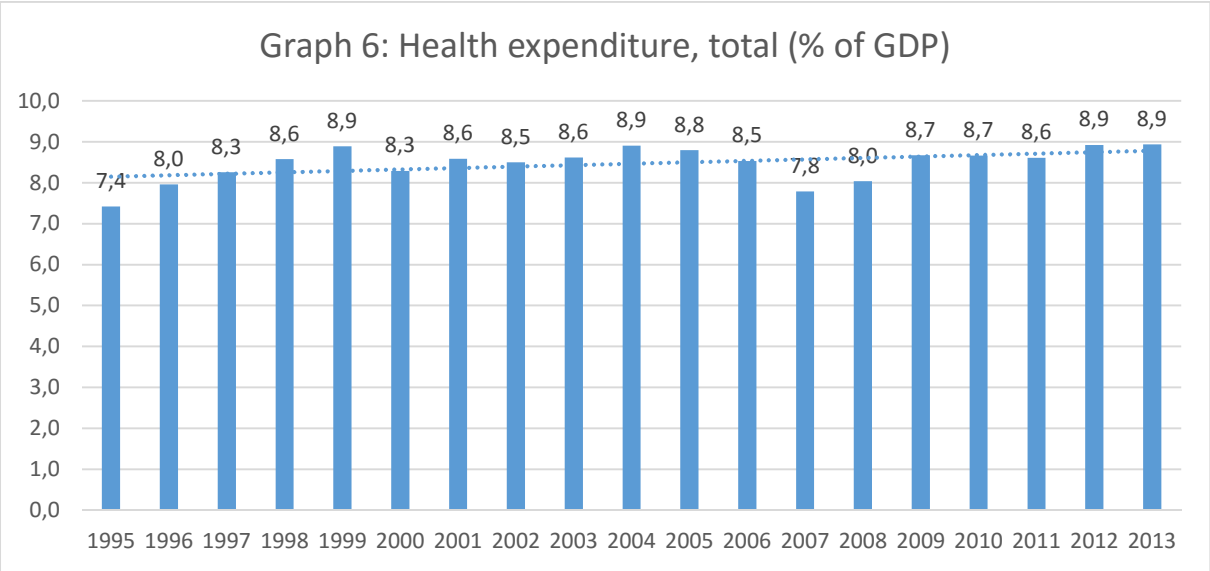
Real health expenditure per capita (measured on a purchasing power parity basis) has more than doubled, increasing by approximately 135 percent, over the period 1995 to 2013.[21]



Source: World Bank, World Development Indicators

Total health expenditure in South Africa has risen from 7.4 percent of gross domestic product (GDP) in 1995 to 8.9 percent in 2013 (see Graph 6 and Table 1 below). Although this rise in expenditure is not as steep as in other countries, there is a clear upward trend in health expenditure as proportion of total GDP.

[21] Total health expenditure is the sum of public and private health expenditures as a ratio of total population. It covers the provision of health services (preventive and curative), family planning activities, nutrition activities, and emergency aid designated for health but does not include provision of water and sanitation. Data are in international dollars converted using 2005 purchasing power parity (PPP) rates.



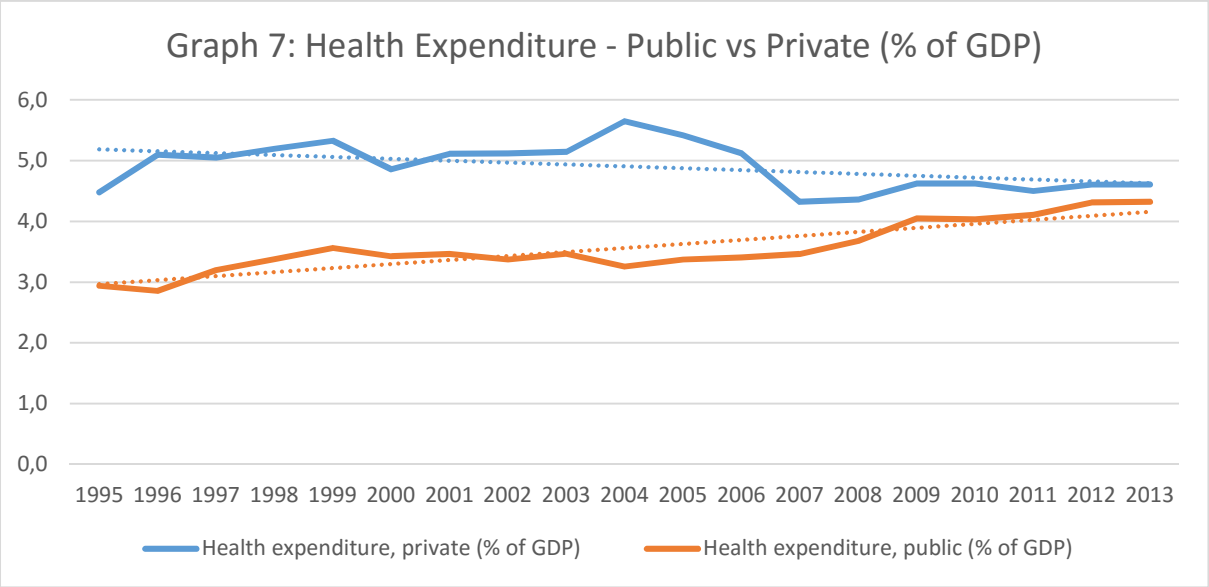
Source: World Bank, World Development Indicators

Table 1: Health expenditure patterns in South Africa, 1995-2013

	Health expenditure, private (% of GDP)	Health expenditure, public (% of GDP)	Health expenditure, public (% of government expenditure)	Health expenditure, public (% of total health expenditure)	Health expenditure, total (% of GDP)
1995	4,5	2,9	10,1	39,6	7,4
1996	5,1	2,9	9,7	35,9	8,0
1997	5,1	3,2	11,6	38,8	8,3
1998	5,2	3,4	12,1	39,4	8,6
1999	5,3	3,6	13,2	40,1	8,9
2000	4,9	3,4	13,3	41,3	8,3
2001	5,1	3,5	13,6	40,4	8,6
2002	5,1	3,4	13,3	39,7	8,5
2003	5,1	3,5	13,3	40,3	8,6
2004	5,6	3,3	11,9	36,6	8,9
2005	5,4	3,4	12,4	38,4	8,8
2006	5,1	3,4	12,2	39,9	8,5
2007	4,3	3,5	12,5	44,5	7,8
2008	4,4	3,7	12,7	45,8	8,0
2009	4,6	4,0	12,9	46,7	8,7
2010	4,6	4,0	13,6	46,6	8,7
2011	4,5	4,1	14,0	47,7	8,6
2012	4,6	4,3	14,0	48,4	8,9
2013	4,6	4,3	14,0	48,4	8,9

Source: World Bank, 2016

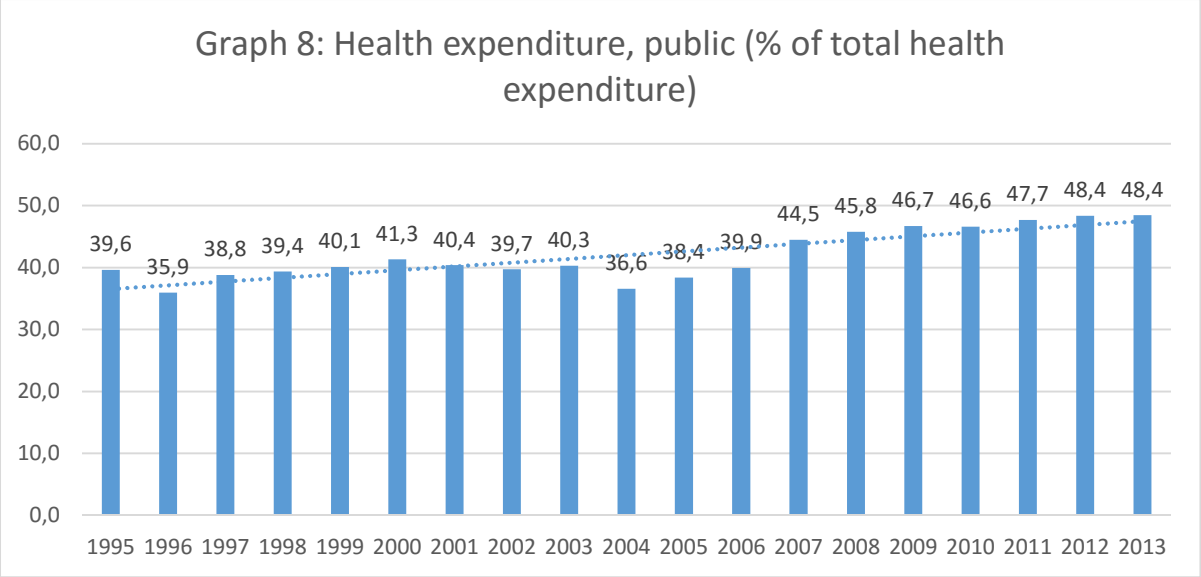
Rising health care expenditure in South Africa is thus not a unique phenomenon and is certainly not confined to only the private sector (see Graph 7 below). In 1995, public health expenditure as a percentage of gross domestic product (GDP)[22] was 2.9 percent. By 2012, this had increased to 4.2 percent. In contrast, private health expenditure as a proportion of GDP[23] has remained relatively constant at 4.5 percent of GDP over the period 1995-2012



Source: World Bank, World Development Indicators

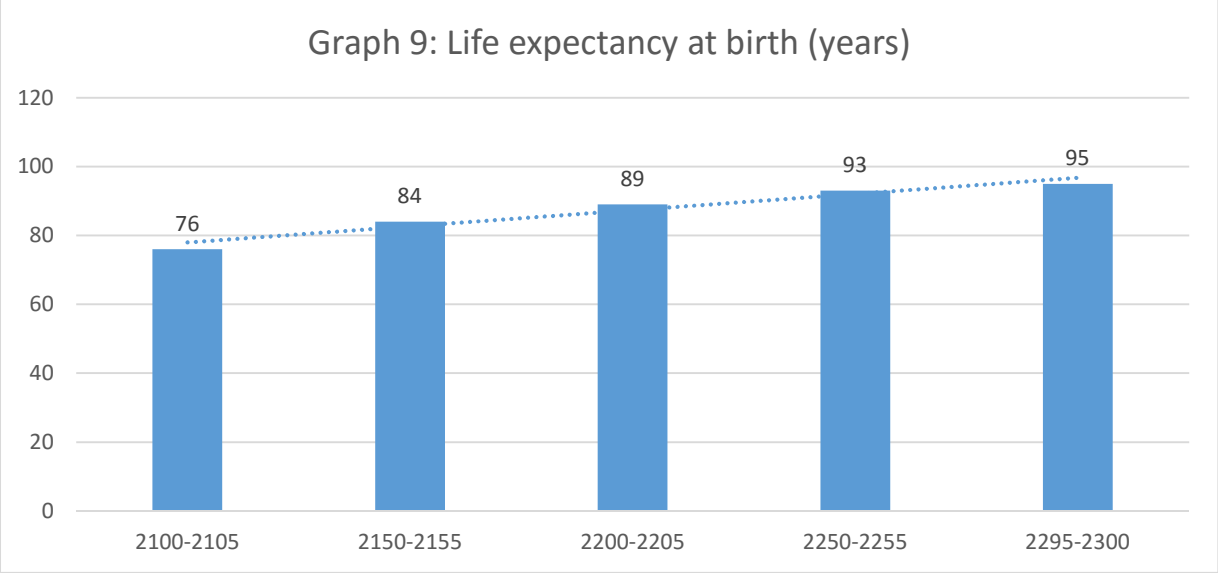
Not unexpectedly, given the rising expenditure patterns in the public sector, public health expenditure as proportion of total health expenditure[24] has been steadily increasing. Since 1995, public health expenditure as a proportion of total health expenditure has risen from 39.6 percent to 48.4 percent in 2013 (see Graph 8 below).

[22] Public health expenditure consists of recurrent and capital spending from government (central and local) budgets, external borrowings and grants (including donations from international agencies and nongovernmental organisations), and social (or compulsory) health insurance funds.
[23] Private health expenditure includes direct household (out-of-pocket) spending, private insurance, charitable donations, and direct service payments by private corporations.
[24] Total health expenditure is the sum of public and private health expenditure. It covers the provision of health services (preventive and curative), family planning activities, nutrition activities, and emergency aid designated for health but does not include provision of water and sanitation.



Source: World Bank, World Development Indicators

As a result of rising incomes, people are also living longer than before. This has resulted in a rising burden of chronic disease that requires more healthcare expenditure. In South Africa, life expectancy at birth has increased from 52 years in 2003 to 57 years in 2013.[25] Moreover, according to the United Nations Population Estimates, life expectancy at birth will continue to rise (see Graph 9 below) and is expected to increase from current levels to reach an estimated average of 76 years by 2100. It is anticipated that life expectancy at birth will continue to rise after 2100 but at a slower rate, reaching 95 years by the year 2295.

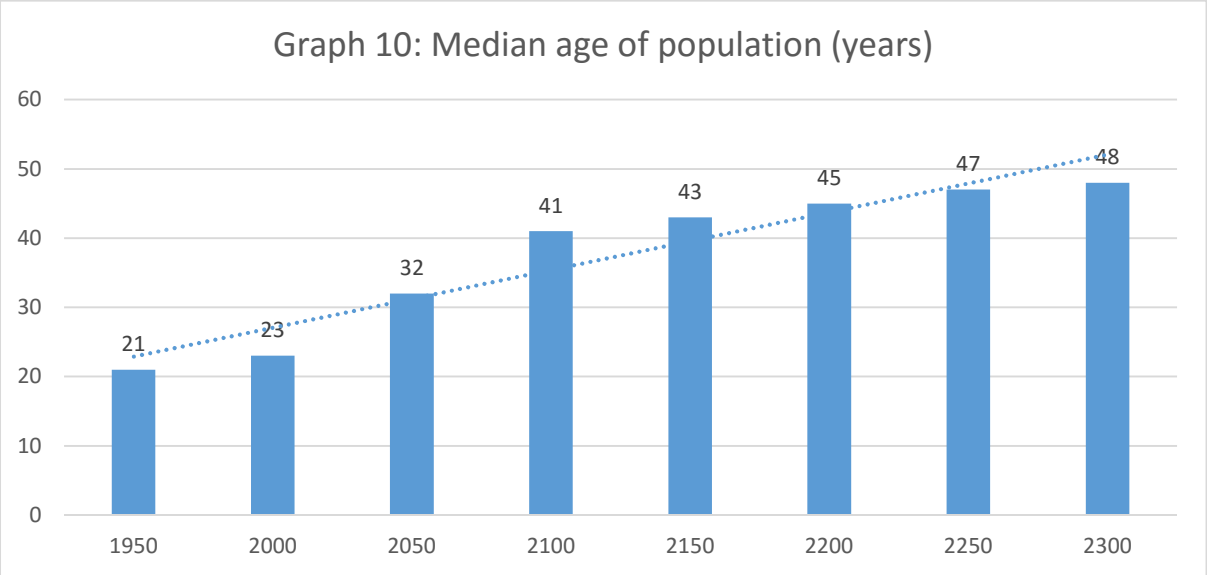


Source: United Nations, 2004

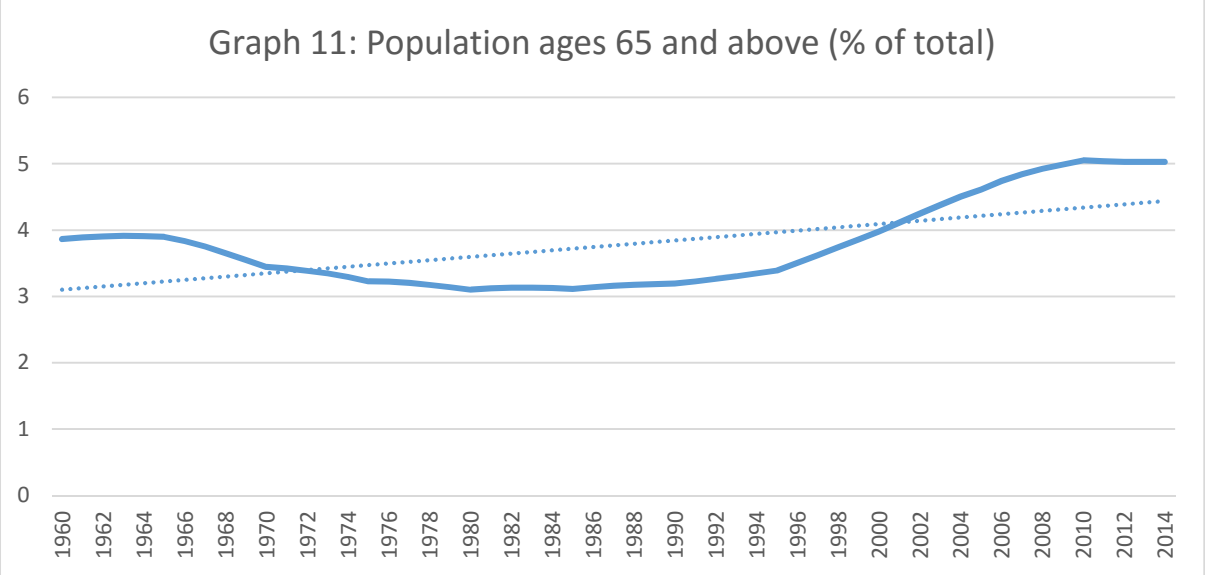
Because of South Africa's aging population, the median age is expected to increase from 23 years in 2000 to 32 years in 2050 and 48 years by 2300 (see Graph 10 below). More importantly, the proportion

[25] World Bank, World Development Indicators.

of the South African population that is aged 65 and above will continue to rise (see Graph 11 below). This aging trend has important implications for healthcare costs.

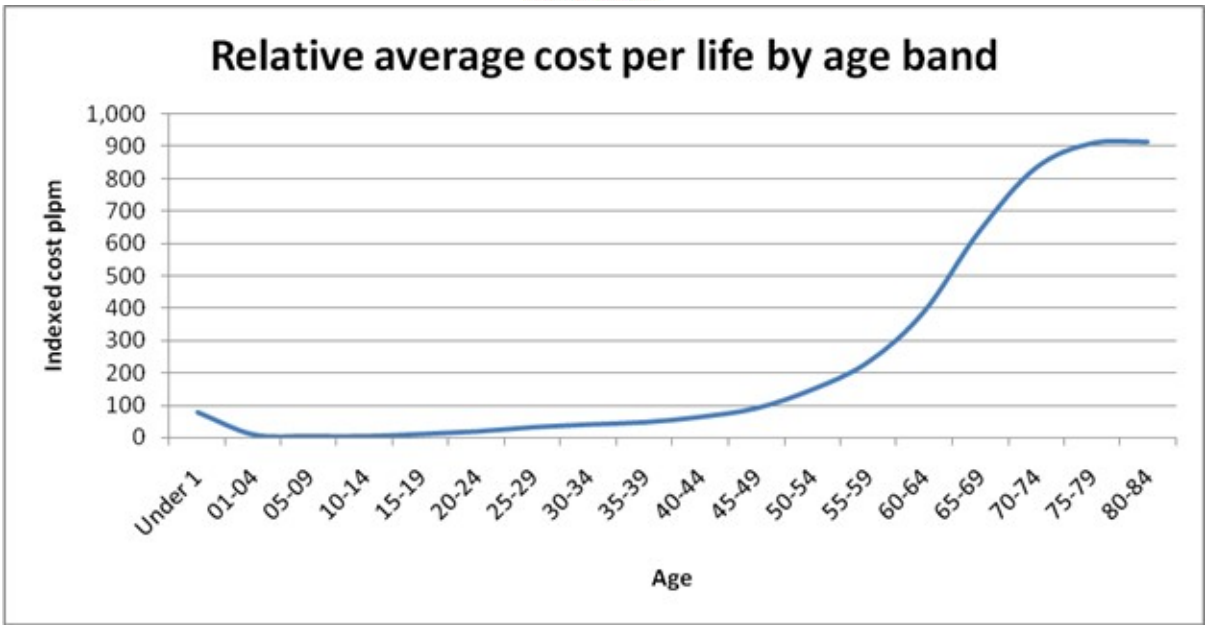


Source: United Nations, 2004



Source: World Bank, 2016

As people age, there is an increased probability that they will require chronic care that. in turn, raises expected medical care expenditure. New innovative technologies that cause people to live longer also raise the price of medical care. According to South African industry sources, the graph below provides a graphical representation of expenditure on health care disaggregated by age group. In general terms, an 80-84 year old individual has monthly average costs about nine times those of a 45-49 year old. Similarly, a 5-9 year-old individual has a cost of about 3 percent of the total costs that a 45-49 year old individual can expect to pay.



Source: Various industry sources

The existence of a "two-tiered health care system"

The White Paper states, "The main contributor to inequity in health care is the existence of a two-tier healthcare system where the rich pool their health care funds and resources separately from the poor".[26] The White Paper seems to suggest that the existence of a so-called "two-tier healthcare system" in South Africa is the fundamental cause of the poor service provision and performance of the entire health care system. More specifically, the White Paper seems to suggest that this poor performance is primarily the result of the existence of the private sector. This is a fundamentally flawed argument. The evidence to the contrary is that the existence of the private health care sector (in all its aspects) is highly beneficial to the people of South Africa, including the poorest members of the population. The White Paper does not address the root cause of the poor performance of the overall South African health care sector, which, according to international surveys, is detrimentally affected by the poor performance of the public health sector. Moreover, according to Statistics South Africa's General Household Survey (2014), only 57.5 percent of respondents stated that they were "very satisfied" with public sector healthcare facilities, whereas 92.2 percent of respondents who utilise private sector facilities, were "very satisfied".[27]

It is not clear why the mere existence of both a private healthcare sector and a public healthcare sector within the South African healthcare market is a valid justification for the introduction of NHI. Moreover, if this is the justification for NHI, and given that the White Paper explicitly states that the private sector will continue to operate under NHI, it is not clear how the two-tiered system will be eliminated.

As noted previously, developed nations have attempted but not succeeded in providing "free healthcare for all" through a single-payer model. We appreciate that the Minister of Health wants to improve access to healthcare, as he should do and as we all do, but NHI seems less concerned about increasing access to quality healthcare for the poor than removing the "two-tier system". The state

[26] Paragraph 77

[27] Statistics South Africa (2015) General Household Survey, 2014. Statistical Publication P0318. Available at: http://www.statssa.gov.za/publications/P0318/P03182014.pdf

does not have to provide "free healthcare for all". It should focus rather on those who need but cannot afford to pay for healthcare and leave the rest of the population to see to their own needs.

It is not clear from the White Paper why it is necessary to establish a single-payer, centrally controlled, NHI-style system to achieve its stated objectives. Many of these ideals are inappropriate. For example, the White Paper states, "The financing and provision of services in the private sector will also have to comply with the principles of access, social solidarity, equity, efficiency, health as a public good, affordability and effectiveness".[28] Despite the fact that the White Paper provides no detail as to how and why it is necessary for privately contracting parties to adhere to these principles, the FMF is of the opinion that health is, in fact, an ordinary commodity just like any other, and thus should be treated as such.

Claims of Healthcare as a "public good"

Healthcare services are most certainly not a public good. Patients can be excluded either through waiting times or through payments (at both private and public facilities) from treatments as there will certainly be rivalry in consumption. Rivalry in consumption always occurs when there are limited numbers of healthcare personnel and facilities available to treat patients.

The White Paper makes sweeping statements about future improvements to the public health sector, yet the NHI focuses on expanding the role of the public sector. The focus should rather be on improving the quality of health care to the poorest people in the country, whilst not meddling with those people who are obtaining health care for themselves through their own resources. For example, the White Paper states, "…Public sector facilities are regularly assessed against core quality standards. This has revealed that there are quality problems in the areas of staff attitudes, waiting times, cleanliness, drug stock outs, infection control and safety and security of staff and patients. In addition, significant increases in utilisation due to the high burden of disease and increased patient loads have further compromised the quality of care".[29]

The proposed NHI is no elixir that will fix public health care by passage of legislation, or by throwing more money at it. A significant reason why public hospitals do not offer the same quality of care as private hospitals is because they do not have the same incentives as the private sector to modernise and maintain their facilities. In South Africa, it takes months, if not years, for the NDOH to recognise the chronic shortages of equipment or health professionals, or that facilities are in desperate need of repair or renewal. Government central planners cannot make timely decisions to modernise healthcare infrastructure. By contrast, consumer choice forces private sector hospitals constantly to modernise, evolve new strategies and invest in new technologies.

[28] Paragraph 153
[29] Paragraph 75

"Proponents of government health systems argue that such systems ensure the optimal and productive utilisation of the country's health-care resources. Their arguments are based on the fallacy that there is someone who actually knows how to allocate health-care resources in an equitable manner and what optimal health resources would comprise. However, as explained by Nobel laureate Friedrich Hayek, such a person or organisation cannot exist. Hayek's writings teach us that government planning cannot achieve the efficiency in the use of resources which market processes make possible because the knowledge required to do so is dispersed among thousands and millions of individuals. All government enterprises and state-controlled companies fall prey to what has become known as 'the knowledge problem' and South Africa is no exception."

Johan Biermann

According to the White Paper, "The main cost drivers (other than human resources) in the public health sector are: pharmaceuticals; laboratory services; blood and blood products; equipment; and surgical consumables. These cost drivers adversely impact on efficient and effective service provision".[30] It should be noted that the healthcare commodities listed are fundamental components of any healthcare system – if the government wants a healthy and productive workforce it cannot escape spending on these items. What it can do, however, is negotiate prices with providers and ensure that providers strictly adhere to their contracts.

We are pleased with government's admission that, "Inefficiencies in the procurement and monitoring of hospital support services such as security, laundry and catering services also contribute to these high costs".[31] But this leads to the inescapable question – if government cannot efficiently and effectively contract with ancillary service providers, how is it reasonably expected to efficiently and effectively operate an entire healthcare system under the proposed NHI? The aforementioned quote from the White Paper should be read in conjunction with the statement, "…essential health support services such as laundry, safety and security must be provided on a continuous and uninterrupted basis. Support services such as security, food supply, cleaning services, and laundry services, must not be outsourced but should be provided in-house within the public health system".[32]

The private sector does not seem to concur with this view as private hospitals outsource most cleaning, food, laundry and other services. Or are they not concerned about efficiency and, thus, profitability? Are these private sector services inefficient and unreliable when supplied to public facilities because government bankrupted many of its service providers through non- and/or late payment? Or might the inefficiencies in government-run facilities have more to do with weak hospital management and poorly enforced and/or conceived contracts?

Moreover, according to Dr Johann Serfontein, the proposed NHI is not only fiscally unachievable but it will also require an "army of bureaucrats" in order to administer it. Dr Serfontein states, "The

[30] Paragraph 64
[31] Paragraph 64
[32] Paragraph 220

Compensation Fund, which is the closest government body to the [proposed] NHI Fund… has an annual income of R8-billion and paid out R1.4-billion in medical claims last year. Yet, it had R23-billion in outstanding claims, more than was paid out in the preceding 10 to 12 years, which constitutes almost half the fund's R52-billion in assets. The previous compensation commissioner was recently sentenced to a three-month suspended jail sentence for failing to comply with a court order in terms of which he agreed to pay outstanding claims in 75 days. The Compensation Fund employs 1,630 people and it paid out R1.4-billion in medical claims last year. In comparison, Discovery Health has five times this number of employees and paid out 26 times the amount in medical claims. The proposed NHI budget is 32 times larger than that of the Compensation Fund and the number of claims payable is likely to be 100 times more, this does not take into account the payment of suppliers. This would require the NHI Fund to employ between 52,000 and 160,000 employees, if judged by Compensation Fund efficiency. In comparison, the entire South African military employs 89,000 full-time people. If the government is unable to run an R8-billion fund efficiently, how is a R256-billion fund going to be different?"[33]

Government, anyway, should not be providing any of these services, including the most critical of all, namely, clinical care. All of these services should be put out to tender and the government should merely ensure that it gets the "best bang for its buck". The private health sector is not responsible for the poor health performance of the public sector – for this the South African government is entirely to blame. We once again reiterate that the proposed rationale for introducing an NHI in South Africa is flawed. The entire South African population already has access to health care and they currently have a choice of paying for services through the private sector or attending public healthcare facilities. A substantial obstacle people attending public sector facilities encounter are the significant waiting periods coupled with a poor level of service. It is for this reason that people choose to pay out of pocket and access the private sector (The so-called "84-16% split").

The so-called "84-16% split"

The White Paper states, "In the private sector, there are 83 medical schemes funding the health needs of only 16.2% (8.8 million lives) of the population".[34] Yet, according to Professors Heather McLeod and Servaas van der Berg, "Though the 16% of the population belonging to medical and bargaining council schemes receive good health services, public healthcare quality is so inadequate that 30% of people without medical scheme cover pay for private treatment out of pocket".[35]

It must be noted that individuals *voluntarily* contribute to medical schemes. This is not the case under the proposed NHI, where certain groups of people, based on their socio-economic status, will be *forced* to contribute to the proposed NHI Fund or else face prosecution and potential jail time if they do not.

In an interview with *Business Day*, the Minister of Health distanced himself from the proposals contained in the White Paper that restrict private medical schemes to "complementary cover"[36] saying that the state should not limit patients' choices. More specifically, the Minister said, "We are not envisaging burning medical schemes outright. The private schemes like Discovery, we don't think it will be fair for anyone of us to say they are no longer going to work. We want people to make their own choice. We want to make it clear that NHI will be mandatory, just like it is in England. No millionaire is not part of the NHS (the British) National Health Service), but if he says he wants to do

[33] http://www.bdlive.co.za/opinion/letters/2016/05/06/letter-nhi-will-need-an-army
[34] Paragraph 81
[35] http://www.bdlive.co.za/articles/2009/09/04/crude-nhi-plan-threatens-to-make-a-bad-situation-worse
[36] Paragraph 399

something privately they will allow it".[37] When asked how he reconciled this vision with the White Paper's proposal that medical schemes provide only "complementary cover" and not duplicate services offered by NHI, he said, "I was a little disappointed that in the White Paper it might appear to be giving the wrong impression. There is nothing wrong with giving a person their own choice, and (to) buy whatever (they want)".[38]

Contributions to private medical schemes are over and above what South Africans already contribute to public health facilities via the general taxation system. If the public sector was a viable alternative, people would have no qualms about using the service, but this is not the case. The government's most important role is to create an environment that leads to the rapid growth of a competitive private sector as opposed to introducing draconian legislation that limits its role and retards its expansion. With increased competition, individuals will have more choice, prices will fall, and quality will improve.

The White Paper states, "In the current system of medical schemes, only those belonging to medical schemes are able to access health services in both the private and public sectors". What nonsense. As noted previously, generally speaking, public sector facilities are so appalling that a significant number of individuals choose to pay out-of-pocket to access private medical facilities.

The White Paper also contentiously states, "Even they [medical scheme members] are usually denied access to health care before the year ends because they are supposed to have run out of benefits".[39] Medical scheme members sign up to an agreed list and value of cover. They do not simply run out of benefits. Medical schemes are not charities; they are obliged by economic realities and the interests of the members of their schemes to take great care in managing available resources. If scheme managers were to recklessly pay claims that are not included in the agreements with scheme members, they would be guilty of dereliction of duty and would threaten the solvency and continued existence of the schemes they are managing. They have to stick to the rules and ensure that they do not bankrupt the schemes

The South African private healthcare sector is not unique and healthcare expenditure is bound to increase. However, as noted previously, the South African private healthcare sector is one of, if not the most regulated sectors in the South African economy, where government instituted controls are pervasive. Government imposed regulations serve to restrict competition and should be amended with immediate effect in order to open the market and allow increased competition within the sector, which is the surest path to lowering prices for consumers without causing serious harm to the enduring supply of health care. For example, in order to relieve the burden on the state, medical schemes should be deregulated so that medical scheme actuaries can develop plans that cater for and individual's needs. At the very least, the medical schemes industry should be permitted to create low-cost benefit options to cater for lower-income individuals.

[37] Kahn, T. (2016) Motsoaledi does not want NHI to limit choices. Business Day 01 February 2016. Available at: http://www.bdlive.co.za/national/health/2016/02/01/motsoaledi-does-not-want-nhi-to-limit-choices
[38] ibid
[39] Paragraph 6

NHI Proposed Funding Options

In his 2016 state of the nation address, President Jacob Zuma stated, "To achieve our objectives of creating jobs, reducing inequality, and pushing back the frontiers of poverty, we need faster economic growth. When the economy grows fast, it delivers jobs. Workers earn wages and businesses make profits. The tax base expands and allows government to increase the social wage. We must act decisively to remove domestic constraints to growth. We cannot change the global economic conditions, but we can do a lot to change the local conditions".[40]

According to John Kane-Berman past chairman of the South African Institute of Race Relations, "Fifteen years ago there were 312 people employed in this country for every 100 on social grants. Now, because we have extended social security faster than we have generated jobs, there are only 86 people employed for every 100 on social grants".[41] The National Development Plan adopted in 2012 warned that South Africa might one day not have enough taxpayers to finance its social security commitments. Since then the risk of running out of taxpayers has increased. As President Zuma correctly noted, the solution is not to remove the grants, but to get more people into work."

The Davis Tax Committee (DTC) acknowledges that to implement the NHI "the tax to GDP ratio will need to rise quite significantly". In the White Paper, the NDOH acknowledges the government's preference for a broad tax base and low tax rate, rather than a narrow tax base and high tax rate.[42] Economic growth, it correctly notes, is a prerequisite for the expansion of the tax base,[43] but, as this section shall demonstrate, South Africa has an extremely small (or narrow) tax base and the country's economic growth forecast is dismal.

"I contend that for a nation to try to tax itself into prosperity is like a man standing in a bucket and trying to lift himself up by the handle."

Winston Churchill

In the current tough economic climate, many South Africans are feeling the pinch as their household debt rises and disposable incomes fall. An over-taxed middle class is naturally feeling cheated as it is being forced to fork out increasing amounts of tax. In 1994, for every rand of tax taken by government, taxpayers retained R2.62, whereas today we hold onto only R1.54. The economy grew 2 percent last year, but the tax to gross GDP ratio increased to 25.7 percent from 24.9 percent and the economic growth forecast for 2016 is a meagre 0.6 percent.

[40] President Jacob Zuma (2016) State of the nation address. Available at: http://www.gov.za/speeches/president-jacob-zuma-state-nation-address-2016-11-feb-2016-0000
[41] Kane-Berman, J. (2016) Dr Zach de Beer Memorial Lecture. Available at: http://www.zjdebeermemorial.co.za/
[42] Paragraph 269
[43] Paragraph 271

More importantly, the White Paper states, "NHI financing requirements are uncertain…".[44] Let us try to add some certainty by looking at the joint publication of the National Treasury and the South African Revenue Service (SARS): *Tax Statistics, 2015.*[45] According to this annual publication, there were 18.2 million individuals registered for personal income tax for the 2014/15 tax year. But, just because someone is registered for tax, does not mean they actually pay personal income tax (PIT). Everybody, though, does pay tax because everyone pays VAT, but PIT is the government's main source of tax revenue – comprising 35.9 percent of total tax revenue – and is being considered the main source of revenue for financing the NHI. Of the 6.6 million people who were liable to submit tax returns, SARS assessed only about 5 million (approximately 75 percent). If we disaggregate the data, we find that the top 10 per cent of taxpayers (approximately 480,000 individuals) with taxable incomes in excess of R500,000 per annum, account for more than half (57.3 percent) of the total income tax assessed.

If we include those with a taxable income in excess of R120,000 per annum, we find that approximately 3.4 million people (68 percent), account for 99 percent of the total personal income tax payment. It should be clear that South Africa has a very narrow tax base and, as the White Paper states, "A narrow tax base requires higher tax rates while a relatively broad tax base requires lower tax rates to generate the same amount of tax revenue. To the extent that high tax rates tend to cause distortions, lower rates and a broad tax base should be preferred".[46] Given South Africa's narrow tax base, it is surprising that the government is even considering imposing yet another tax on already overburdened taxpayers rather than trying to allow more people to become actively involved in the workforce

The "uncertain" funding sources proposed in the White Paper will be difficult, if not impossible, to implement. Government should use funds already at its disposal and not impose further taxes on an already overtaxed population. Proposed mandatory payments into a central NHI Fund will crowd out private insurance as many individuals, unable to pay voluntary private insurance premiums on top of compulsory NHI Fund payments, will be forced to move to an already over-stretched, public health service.

Given South Africa's level of economic development and vast social problems, which include but are not limited to, a high level of unemployment, poverty and high crime rates; it is seriously doubtful whether we are in a position to afford an ambitious proposal such as the NHI. We are of the view that the introduction of an NHI will place an unnecessary and intolerable burden not only on South Africa's people but also the South African government – a burden that will be felt for many generations to come if it is introduced.

Once again, we can only speculate how it is envisaged that the proposed system will be funded. It has been suggested that the NHI will be funded out of either:

- A surcharge on taxable income;
- A specific progressive payroll tax for taxpayers above a minimum tax threshold;
- An increase in value added tax (VAT); or
- A combination of these three sources.

Before the government contemplates introducing yet another tax (or increasing any existing tax rate), it is important to consider the implications.

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[44] Paragraph 293

[45] Tax Statistics, 2015. A joint publication between National Treasury and the South African Revenue Service. Available at: http://www.treasury.gov.za/publications/tax%20statistics/2015/TStats%202015%20Inside%20WEB.pdf

[46] Paragraph 269

Increasing VAT hurts the poor

Although some individuals might find the idea of raising VAT to fund NHI politically palatable, raising VAT is a bad idea as it will disproportionately affect the very people that it is supposedly trying to assist. VAT is what economists refer to as a regressive tax. Whether rich or poor, the amount we pay on a certain product as a percentage of its price is the same. The tax burden for a given product, therefore, forms a larger share of a poor person's income than that of a rich person. Increasing VAT, therefore, will make poor people worse off and increase inequality.

The Davis Tax Committee (DTC) acknowledges this fact in its first interim report on VAT. The DTC finds that "…an increase in VAT would have a greater negative impact on inequality than an increase in personal income tax or company income tax. Should it be necessary to increase the standard rate of VAT, it will be important for the fiscal authorities to think carefully about compensatory mechanisms for the poor who will be adversely affected by the increase. A range of measures should be considered, such as increases in social grants or the strengthening of the school nutrition programme".

Increased taxing of the sickest and most vulnerable members of society and then off-setting the increased tax with a compensatory mechanism is counter-intuitive. The government needs to bear in mind that it should not prevent people improving their quality of life, especially the poorest members of society. If we assume government wants a healthy and productive workforce, a more logical approach would be to *eliminate* VAT on pharmaceutical products and devices to increase access to these goods. For example, exempting medicines – or at least medicines contained on the WHO's Essential Medicines List – from VAT would have a number of beneficial outcomes. These include but are not limited to the following:

- Increase access to medicines by lowering the cost of pharmaceutical drugs;
- Reduce the cost of self-medication, encouraging patients not to use their GP when it is not necessary; and
- Reduce the administrative burden for community pharmacies (and the Treasury) who have to reclaim VAT.

Taxes on medicines are highly regressive and severely penalise the poorest and most vulnerable members of society. In a democratic state, to remove them should be both politically popular and feasible. Rather than increasing VAT to fund the proposed NHI scheme and in the process "hurting poor people to help them", government should first consider eliminating taxes that keep essential medicines out of the hands of the poorest of the poor and reducing the VAT burden.

Surcharge on taxable income and a payroll tax

Taxes interfere with the ability of individuals to pursue their goals and, as the White Paper correctly points out, increased economic activity is the key. The White Paper states "…Increased economic activity ultimately contributes to poverty alleviation, better quality of life and human development and will reverse the significant income inequalities in the country".[47] One of the surest ways to boost economic activity is to reduce taxes and encourage savings and investment.

A lack of investment retards capital accumulation and a lower capital to labour ratio reduces real wages and perpetuates the poor savings and investment cycle. Without investments to fund and establish new ventures that create jobs, the smaller the economy and the lower the economic growth rate will be. The government, therefore, would do well to avoid inflicting further pain on South

[47] Paragraph 114

Africans by increasing taxes. The White Paper actually acknowledges this when it states that "A higher overall personal income tax burden would impact on the disposable income of households and…on consumption expenditure and economic activity. A further concern with this option is the potential negative impact on savings".[48]

Since the main funding option for the NHI scheme will necessarily come from a surcharge on taxable incomes and or a payroll tax, the NHI would be a tax on labour. A payroll tax is ultimately borne by workers, either in reduced compensation or job losses. Once again, the White Paper acknowledges the link between payroll taxes and reduced employment opportunities. It states, "Payroll taxes…add to the costs of employment…(and) the impact of higher payroll taxes on overall employment and job creation has to be considered carefully. High payroll taxes can lead to a bias against formal sector employment, and an increase in informal and unprotected work…".[49]

Forcing employers to do "the right thing" may be politically attractive for politicians but would effectively lower wages and destroy jobs – precisely the opposite of what the poor in this country require. As mentioned previously, a tax on labour leaves workers with less disposable income to spend on things that improve their lives, and less money for savings and investment. It is worth reiterating that without investment to fund new ventures, there will be fewer job opportunities and lower economic growth. So while the NHI scheme is supposed to help people access medical care, it would, instead, undermine their chances of economic success by either cutting their wages or eliminating their jobs altogether. In short, adopting the proposed NHI has the potential to wreck South Africa's already weak economy. Government spending has to be curbed. The government must adopt policies that promote economic growth and address unemployment, which has relegated almost 9 million South Africans to lives of hopelessness.

The NHI white paper notes that "productive public expenditure" will encourage economic growth, ignoring that the government has customarily mismanaged funds and resources, especially within the government health infrastructure. Rising expectations and the government's willingness to continuously spend more, will place an impossible burden on taxpayers. The recent leadership fiasco within the finance ministry is no consolation.

The following statement contained in the White Paper is both confused and confusing: "In the long run households will also benefit from increased disposable income as a result of a significantly lower mandatory prepayment". There is currently no mandatory prepayment – all contributions to private medical schemes are voluntary – and thus it is impossible to pay an amount "significantly lower" than zero. More importantly, the proposed NHI will itself introduce a mandatory prepayment – that is the basic underlying premise of the NHI. Moreover, despite the lack of clarity contained on the funding options that are to be used to raise taxes to fund the NHI, what is clear is that taxes will undoubtedly rise – as the DTC has confirmed – and thus disposable incomes will *ipso facto* fall.

[48] Paragraph 288
[49] Paragraph 285

How much will NHI cost?

The White Paper figures are based on "a modified costing from the Green paper on NHI". This leads to a number of questions such as:

- Why, after a period of no less than four years having elapsed since the publication of the Green Paper, have there been no new cost estimates?
- Where is the Treasury analysis that was supposed to be released in conjunction with the White Paper?
- What are the costing figures based on – the White Paper has still not provided any details on the so-called "comprehensive package of health services"?

"If you think health care is expensive now, wait until you see what it costs when it's free!"

P.J. O'Rourke

In an interview with *Business Day,* the Minister of Health dismissed the costing figures presented in the White Paper when he said, "NHI is a long-term project that should be financed on a programme-by-programme basis".[50] Setting aside the fact that the Minister should have known what was presented in the White Paper, something that he had signed off, we dispute the assertion that NHI will be adopted on a programme-by-programme basis, since, as stated in the White Paper, "NHI represents a substantial policy shift that will necessitate a massive reorganisation of the current health care system, both public and private…".[51] The statement "…focussing on (the) question of 'what NHI will cost' is the wrong approach"[52] we found particularly disingenuous.

Without any consideration of costs, adopting the NHI could be disastrous considering the very serious implications for the economy of adopting the scheme. Given the lack of details on what exactly the NHI will cover at this point it is impossible to do an exact calculation of what the NHI will cost. However, we have done some "back of the matchbook calculations" and if we assume a modest R567, which happens to be average cost per beneficiary per month for the Prescribed Minimum Benefits, then the cost per person per annum is R6,804. Considering South Africa's population of approximately 54 million people, we can estimate that the NHI will cost about R367.4-billion per year. When one considers that in the 2014/15 tax year, total personal income tax collections – government's main source of tax revenue – amounted to only R353.9-billion, one starts to get some idea of the futility of this ambitious proposal.

In the following quote, Prof Anne Mills (Head of the Health Economics and Financing Programme of the London School of Hygiene and Tropical Medicine), as part of her input into the 1994 Finance Committee established by the Department of Health to advise on NHI, succinctly summed up the situation regarding the appropriateness of a NHI-style system for South Africa

[50] Khan, T. (2016) Motsoaledi does not want NHI to limit choices. Business Day, 1 February 2016. Available at: http://www.bdlive.co.za/national/health/2016/02/01/motsoaledi-does-not-want-nhi-to-limit-choices
[51] Paragraph 2
[52] Paragraph 250

"It is clearly financially unaffordable to offer universally either the benefits currently on offer in medical aid schemes, or free and complete in the public sector. Benefits would therefore have to be severely restricted. However, it is difficult to see how this can be achieved because the setting up of a universal scheme would raise expectations about access to care. Moreover, the scheme would put in place a financing mechanism before having in place the health service infrastructure to satisfy demand. Benefits would inevitably be unevenly available, causing justifiable grievance."

Professor Anne Mills

SA suffers from a chronic shortage of skilled healthcare professionals

Given the chronic shortage of skilled healthcare professional in the country, we were intrigued to read in the White Paper about the government's plan to increase the number of doctors in South Africa. "…Through the Nelson Mandela-Fidel Castro collaboration, a medical training programme was established in Cuba alongside the recruitment programme. As a result of this collaboration there are 3,344 medical students training in Cuba as at 2014. The domestic training platform has been expanded since 2011 by increasing student intake and plans to build new medical schools or to expand existing ones are in place".[53]

Increasing student intake and allowing the private sector to train doctors

For many years the FMF has suggested that to alleviate the chronic shortage of doctors, government should increase its intake. But more can and should be done. Every year thousands of potential candidates, even those who achieve distinctions in their matric examinations, are turned away because the number of positions available at South Africa's government-run medical schools is limited to about 1,500 per year. This number is only fractionally higher than that set in the early 1970s, in spite of the country's rising disease burden and a population that has more than doubled.

Yet the government refuses to allow the South African private sector to train doctors, based on the dubious premise that this will mean that individuals from poor communities will never be able to become doctors. These sentiments are wrong on at least two counts. Firstly, the availably of spaces in the private sector will not diminish the positions available at the existing government-controlled medical schools, and, secondly, the private sector is perfectly capable of identifying young, bright, candidates and offering them bursaries.

There is no reason for the government to hold a monopoly on the training of doctors and artificially restrict the number of doctors that South Africa produces. A long-term strategy would be to allow the private sector to establish private medical schools so that thousands of South Africa's brightest students can pursue their dream of studying medicine. Whether the schools operate on a for-profit or non-profit basis, their establishment can only alleviate the problem. If this is done, a significant part of the burden currently faced by the public health sector will be eliminated.

South Africa's private hospitals are well-established centres of excellence and world-renowned for their high levels of care. Privately run education facilities, if conducted in co-operation with these hospitals, will attract a significant number of internationally recognised lecturers, which will increase the available pool of knowledge, as well as international students, who, potentially, will stay and continue to work in South Africa. Privately run medical schools will not solve the chronic medical staff shortage overnight but will certainly aid any long-term effort to increase the number of medical professionals in the country.

In terms of the ethical rules of the Health Professions Council of South Africa (HPCSA), private hospitals are prevented from appointing doctors and other health professionals, with the exception of nursing staff. Since private hospitals cannot appoint doctors directly, they offer incentives to attract various healthcare professionals to establish practices within hospital premises. These incentives can cause the price of services to rise. Doctors and specialists should be allowed to work wherever they choose

[53] Paragraph 36

without restriction or being tied to the public sector and the private sector should be allowed to train doctors, which would not only increase the available supply to the private sector but also the public sector.

"Cuba's Slave Trade in Doctors"

We found it highly ironic that although the White Paper seeks to put an end to outsourcing, it chooses to continue to outsource the training of doctors to Cuba, a country that has, not only an atrocious human rights record, but also a completely different disease profile – not to mention a minor impediment of having to receive training in a completely foreign language.

Medical missions from Cuba are paid for either by the host country's government or by donor countries that send funds to the WHO. According to *The Wall Street Journal*'s Mary Anastasia O'Grady, "The money is supposed to go to Cuban workers' salaries. But neither the WHO nor any host country pays Cuban workers directly. Instead, the funds are credited to the account of the dictatorship, which by all accounts keeps the lion's share of the payment and gives the worker a stipend to live on with a promise of a bit more upon return to Cuba".[54]

Cuba's medical personnel are not forced at gunpoint to go on these missions but they often have little choice. Cuban doctor, Antonio Guedes, who now lives in exile in Madrid, told German broadcaster Deutsche Welle that, "Whoever does not co-operate may lose his job … or his son will not get a place at university".[55] So it is not exactly mandatory, but it is not exactly voluntary either and with the state surveillance system, health workers dare not speak out against the regime. Cuba is one of the world's most repressive countries. *Freedom House* ranks it as one of the least free nations. In terms of economic freedom, it is ranked second last, one place ahead of North Korea, in the Heritage Foundation's *2015 Index of Economic Freedom*. Not surprisingly, the average worker in Cuba earns less than $22 (R252) a month.

[54] Anastasia O'Grady, M. (2014) Cuba's Slave Trade in Doctors. Wall Street Journal 09 November 2014. Available at: http://www.wsj.com/articles/mary-ogrady-cubas-slave-trade-in-doctors-1415573715

[55] http://www.dw.com/en/cuban-doctors-fight-ebola-in-west-africa-voluntarily/a-18021288

Alternative solutions to the proposed NHI scheme

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

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

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

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

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

Government should concentrate its efforts and scarce taxpayer resources on those who cannot afford health care. For these individuals, government could act as financier and let people decide for themselves where to spend their money – it is not necessary to finance the healthcare needs of the *entire* population. Doing so is not a particularly good use of scarce taxpayer resources. Spending in

one area of the economy necessarily comes at the expense of other areas, so, if the government decides to dedicate more of the budget towards healthcare, it will mean less money available for such essential services as education, policing, sorting out the country's electricity crisis, and the looming water crisis etc.

In order to fulfil the task of acting as financier for the poorest of the poor, government can and should enlist the support and help of the private sector by contracting out those services that can be provided more efficiently by private providers and administrators.

Summary and Conclusion

The White Paper does not explain how South Africa, which is a relatively poor country, will succeed in providing equitable health care to all through the envisaged NHI system, when even wealthy countries have failed in their attempts to do so. When you add to that increased costs, antiquated infrastructure and an aging population, it is seriously doubtful whether the government is justified in wanting to introduce a single payer NHI-style system.

New investment in the health sector is an essential priority given the potential crisis, but government has a poor track record in investing and maintaining public sector infrastructure. It is, therefore, reasonable to assume that new investment will not be forthcoming in the future. It is essential for the private sector to continue to play a significant role in South Africa's health care. Considering the fact that medical schemes provide the main channel for accessing private health care, it goes without saying that legislation which impacts this sector will directly affect the private provision of health care.

South Africans will lose their world-class private health care firms if government's health-care plans continue in the direction of nationalisation. Individuals' freedom to choose their own health care, which is such a vital and personal service, will be severely curtailed under the proposed system. If government views "health care for all" to be politically essential, it could require the population to privately and individually purchase mandatory cover to insure against catastrophic health-related events but otherwise leave people to provide for their own and their families' medical-related and other needs.

Furthermore, instead of the government undertaking the management of taxpayer-provided funds intended for covering the medical costs of the poor itself, it should put the task out to tender. In the same way as people have many options to choose from in household insurance, car insurance and myriad other products and services, publicly-funded patients will then have a multiplicity of medical schemes to choose from. Competition between public hospitals and clinics, and with private facilities, to win business from taxpayer-funded public health insurance beneficiaries, will thrive and ensure that the best service for the best price is given.

Government's "laying the foundations for NHI" before the merits of the proposed system have been adequately discussed is putting the cart before the horse and comes at a cost for every person in South Africa, rich or poor. Finally, the NHI White Paper is thick on populist rhetoric and thin on critical details to make an informed decision on the health and economic impacts of the proposal. South Africa is facing an important tipping point that affects not only each and every one of us but also our children and grandchildren and generations to come. We can either choose systematic deregulation of the private sector on both the funding and provision sides, or we can choose even tighter controls where all of our health care decisions are governed from the cradle to the grave. We need to have the courage to recognise the impending disaster and correct the mistakes before they are made.

If South Africans want better health outcomes then we should be focussing on the institutions that we know result in higher levels of economic growth. South Africa's proposed National Health Insurance (NHI) is premised on a principle of compulsion – an anathema to personal and economic freedom. It is only with economic growth and increased incomes that South Africans will gain greater access to medicines and hospital services. Government, therefore, should focus on adopting policies that foster economic growth by increasing the level of economic freedom in the country. The evidence that greater levels of economic freedom and increased wealth lead to better health outcomes is clear and unambiguous.

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