FREE MARKET FOUNDATION

National Health Insurance Implementation Structures

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.

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.

Introduction

The National Department of Health (NDoH) published the second and final call for comment on the NHI implementation structures and invited interested persons to submit comments and representations on the structures, terms of reference, and the composition of the committees (henceforth NHI Implementation Structures). 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, enabling it to provide services to an increasing percentage of the population.

National Advisory Committee on Consolidation of Financing Arrangements

Primary Objectives

According to the NHI Structures document, one of the primary objectives is "[To establish] a single financing pool with a single purchaser [and this] requires the clear identification of transitional arrangements and structures. The current financing structure is significantly fragmented".[1] The NDoH, however, has failed to provide any substantive evidence to support the notion that a single financing pool with a single purchaser will improve efficiencies and thus result in better health outcomes for South Africans. It has also failed to provide any evidence that it has the ability (or track record) to administer a single payer and purchaser system. The NDoH states that the single payer and single purchaser form of NHI that it seeks to introduce will require the "establishment of strong governance

[1] NHI Implementation Structures, pg. 18

mechanisms and improved accountability for the use of allocated funds".[2] However, as the Auditor General has repeatedly pointed out, the NDoH is one of the worst performing departments in the country and regularly receives qualified audit outcomes.[3]

It should be noted that the FMF supports the principle of Universal Health Coverage (UHC). However, we are opposed to the introduction of a single payer and single purchaser model of UHC. The World Health Organization (WHO) defines UHC as "Ensuring that all people have access to needed promotive, preventive, curative and rehabilitative health services, of sufficient quality to be effective, while also ensuring that people do not suffer financial hardship when paying for these services. Universal health coverage has therefore become a major goal for health reform in many countries and a priority objective of WHO".[4] The WHO, however, does not prescribe how UHC is to be achieved.

The WHO recommends that countries should find ways to "pool funds, …so as to spread the financial risks of illness across the population" and avoid crippling health care costs for both the poor and the rich. But it also stresses that nations must choose the systems that suit them best – and that whatever option is adopted must be affordable in the long-term. The WHO further categorically states, "UHC does not mean free coverage for all possible health interventions, regardless of the cost, as no country can provide all services free of charge on a sustainable basis".[5]

Pervasive capacity constraints within healthcare systems in lower income countries have been recognised as a significant factor hindering success towards UHC. Without a sufficiently skilled human resource base and functioning infrastructure, no amount of money can guarantee effective care.[6,7]

Global organisations such as the United Nations Children's Fund (UNICEF), the World Bank, and the Rockefeller Foundation take the view that many countries will find it difficult to achieve UHC straightaway and should instead focus on a limited set of cost-effective interventions as the first step towards achieving the goals embedded in the Alma-Ata Declaration, which seeks to protect and promote the health of all people by increasing access to Primary Health Care (PHC) services.[8] This model involves significant private-sector participation and is prevalent within resource constrained health systems.[9]

There remains significant opposition to private sector involvement in healthcare, particularly in South Africa. Prof Dominic Montagu, however, points out that "The idea that involving the private sector is antithetical is bizarre…more than two-thirds of all OECD countries rely mostly on private outpatient care and some of the best performing countries also deliver the majority of inpatient care through

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[2] NHI Implementation Structures, pg. 18

[3] Irregular expenditure at R46bn – Auditor General. Available at: http://www.politicsweb.co.za/documents/irregular-expenditure-at-r46bn--auditor-general

[4] World Health Organization (2017). Accessed: 27-07-2017. URL: http://www.who.int/healthsystems/universal_health_coverage/en/

[5] World Health Organization (2017) Accessed: 27-07-2017. URL: http://www.who.int/mediacentre/factsheets/fs395/en/

[6] ibid

[7] Gillam, S (2008). Is the declaration of Alma Ata still relevant to primary healthcare? BMJ 336, 536–538.

[8] http://www.who.int/publications/almaata_declaration_en.pdf

[9] Stuckler, D, Feigl, AB, Basu, S & McKee, M (2010). The political economy of universal health coverage, in: Background Paper for the Global Symposium on Health Systems Research. Geneva: World Health Organization.

private hospitals".[10] Moreover, Prof Montagu states, "The private sector also provides up to 80% of healthcare in many developing countries".

In the South African context, private health insurance provides the main vehicle for accessing private healthcare services and given the significant amount of financial and human resources located within the private sector, the continuation and expansion of this sector is of vital importance to South Africa's overall health and welfare.

A single payer and single purchaser model is simply not appropriate for a poor developing country such as South Africa. Even advanced, developed countries are struggling to meet the healthcare demands of their citizens under single payer models. Ample evidence exists of how government involvement in healthcare increases costs, erodes quality, and thwarts innovation.[11,12,13] 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.

Terms of Reference

a) The Committee will be responsible for implementing the consolidation of financing arrangements

The NHI Implementation Structures document states, "The consolidation of funding streams into 5 transitional funding arrangements will effectively reduce the current fragmentation and through a process of income cross-subsidisation allow for the transition towards the establishment of a single financing pool without having to wait for the raising of additional funding through the tax system".[14]

One of stated reasons for introducing the NHI is to remove the so-called "two-tiered system" of healthcare financing. Indeed, the NHI Policy Paper[15] published in June this year seems to suggest that the existence of a "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 NHI Policy Paper seems to suggest that this poor performance is primarily the result of the existence of the private sector.[16]

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 NHI Policy Paper does not address the root cause of the

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[10] Universal health coverage and private hospitals are not mutually exclusive. URL: https://www.theguardian.com/global-development/2015/may/18/universal-health-coverage-private-sector-world-health-organisation

[11] 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

[12] 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

[13] Fraser Institute (2008) The Hidden Costs of Single Payer Health Insurance. Available at: https://www.fraserinstitute.org/sites/default/files/HiddenCostsSinglePayer.pdf

[14] NHI Implementation Structures, pg. 18

[15] National Health Insurance for South Africa – Towards Universal Health Coverage

[16] ibid

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.

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. If the justification is to remove the two-tiered system and given that the NHI Policy 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 under NHI. Moreover, the consolidation of funding streams into 5 transitional funding arrangements will increase the current fragmentation, not reduce it.

c) Implementation within formal sector employment structures

The NDoH plans to "[Replace] PMBs with the comprehensive benefit structure".[17] The so-called "comprehensive benefit structure" has not been adequately defined and thus it is difficult to make a meaningful comment on this proposal. However, the NHI Structures document implies that the "comprehensive benefit structure" will be "expanded beyond PMBs to include the full range of services as outlined in the NHI package".[18] This will be fiscally unaffordable. Given the lack of detail on the "comprehensive benefit structure", it is impossible to do an exact calculation of how much the NHI will cost. However, if we assume a modest R610 per person per month, which was the average cost of providing PMBs in 2016, this will equate to R7,200 per person per annum. According to Statistics South Africa, the mid-year population estimate in 2016 was 55.91 million. We therefore estimate that a policy of providing the PMBs alone will cost the economy approximately R403 billion per annum. Considering that total revenue from personal income tax collections – South Africa's main source of tax revenue and the main vehicle for financing NHI – amounted to only R389 billion in 2016, we get some idea of the futility of the proposal.

d) Introduction of Mandatory Cover and Contributions related to Formal employment

The NDoH states, "Through a series of changes to existing legislation, mandatory cover and contributions will be introduced for all individuals in formal employment". We have previously warned that mandatory contributions will not only remove consumer choice but will also have far-reaching economic consequences. We are gravely concerned that the NDoH seeks to introduce a financing mechanism for NHI before the services and administrative capacities are in place to deliver such services. It is also not clear how the NDoH can insist on formal sector employees and employers paying for NHI services when the NHI Policy Paper noted that "vulnerable groups"[19] will be "prioritised for registration and delivery of services".[20] In other words, formally employed individuals will be forced to pay for services that they may not necessarily be entitled to receive.

Before the government contemplates introducing a policy that requires a "mandatory cover and contributions … for all individuals in formal employment", perhaps it would be prudent to more carefully consider the country's economic circumstances. In addition to a dismal economic growth forecast of a meagre 0.7 percent for 2017, South Africa suffers from the world's highest and most enduring unemployment problem. South Africa's high and rising unemployment crisis has been a regular fixture since, at least, the mid-1970s. To introduce the proposed NHI before addressing the country's chronic unemployment situation will "put the cart before the horse".

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[17] NHI Implementation Structures, pg. 19

[18] NHI Implementation Structures, pg. 19

[19] **Vulnerable groups**: Refers to population groups that include women, children, older persons and people with disabilities as described in Chapter 1, Section 4 (2) (d) of the National Health Act, 61 of 2003) and the various subsequent sections of the NHA.

[20] NHI Policy Paper, pg. 2

The single biggest problem facing the country is the chronic and persistent unemployment problem. According to Statistics South Africa (Stats SA), the official unemployment rate is currently 27.7 percent (3Q2017), which is the highest recorded unemployment rate since Stats SA began collecting unemployment statistics for the Quarterly Labour Force Survey. This means that over 6.2 million people are unemployed in South Africa.[21]

The strict definition of unemployment, however, is not a very good indicator of what is happening on the ground. Many unemployed people have simply given up searching for work – over two-thirds (67.3 percent) of the unemployed 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 so-called "discouraged work seekers". The expanded definition reveals that 36.8 percent of the working-age population are unemployed, this equates to more than 9.4 million unemployed people.[22]

Because of this massive unemployment problem, South Africa suffers from relatively low levels of income, 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 has caused South Africa's credit rating to be downgraded and will therefore necessitate much higher borrowing costs and – the government has already begun implementing NHI.

The NHI Implementation Structures document states, "The policy intent is to ensure that in line with White Paper on NHI, that employers contribute towards the cost of cover of employees and their dependants".[23] To the best of our knowledge we are not aware of any published NHI document referring to employers covering the cost of their employees *and* their dependents. This is an entirely new proposal and will most certainly require a proper Regulatory/Socioeconomic Impact Assessment (RIA/SEIA). For the people to have a say in the decisions that affect their lives, they must know how the decision was arrived at and on what basis, and their participation must be meaningful and not merely a façade (in other words, government must engage in good faith). Without a SEIA, the public cannot participate in the policy- and law-making processes as mandated by the Constitution.

Without published SEIAs, government is called upon to *judge for itself* whether its *own* policies are reasonable, and this would make the Rule of Law a redundant concept. The incumbent Anton Mostert Chair of Intellectual Property Law, Prof Sadulla Karjiker, states, "Law aims to provide the necessary certainty, or predictability, by which persons can organise their affairs. In the absence of legal rules, disputes will be determined by those who have authority, according to their own ethical, or political, preferences. If there is no requirement that disputes be settled according to legal rules or principles, there would be no need for lawyers, or, indeed, the law. Disputes would simply be settled by ethicists, or politicians, most probably, the latter, as they would have the authority to impose their will on others".[24] What Prof Karjiker was essentially alluding to is the supremacy of the Rule of Law.

The Rule of Law is a principle of South African constitutional law found in section 1(c) of the Constitution.[25] It provides that South Africa is a democratic state founded on the supremacy of the Constitution *and* the Rule of Law. The most important tenet of the Rule of Law is its prohibition on arbitrariness. Arbitrariness is not only a symptom of unfair and bad governance, but is also very

[21] Statistics South Africa (2017) Quarterly Labour Force Survey, Quarter 3, 2017.
[22] ibid
[23] NHI Implementation Structures, pg. 19
[24] Prof Sadulla Karjiker (2017) IP: Politics and Beyond. Inaugural lecture
[25] Constitution of the Republic of South Africa, 1996. Henceforth "the Constitution".

harmful to the economy as it leads to uncertainty and means people and businesses cannot plan their affairs ahead of time.

The opposite of arbitrariness is reasonableness. Reasonableness consists of two elements, namely, rationality and proportionality. Proportionality means that there must not be an imbalance between the adverse consequences of a policy and the beneficial consequences.[26] Rationality means that evidence must support the policy. Stated differently, there must be a rational connection between the purpose of the policy and the solutions proposed.[27] It has also been said that a third element, effectiveness, is a part of reasonableness.

To determine whether a policy will have the consequence intended by the enacting authority, a SEIA must be done as a matter of course, and must be publicly available to satisfy the principle of transparency. If a SEIA is not conducted, it means the intervention is not supported by evidence and is therefore irrational and unconstitutional. If a study is not released to the public, government is failing to comply with section 195(1)(g), and the process is unconstitutional.

Forcing employers to subsidise their employees and their dependents may be attractive rhetoric for politicians, but such efforts would effectively lower wages and destroy jobs – precisely the opposite of what the poor in this country require. Without investment to fund new ventures, there will be fewer job opportunities and lower economic growth. Whilst 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.

e) Pricing Reform and Uniform benefits

Nobel Prize winning economist Friedrich Hayek said, "*The curious task of economics is to demonstrate to men how little they really know about what they imagine they can design".* Price controls seem to be a favourite policy intervention by legislators because they assume that, by a simple stroke of the statutory pen, access to the commodity in question will increase. They are mistaken. The market is far more complex and the price mechanism, which plays an intricate role in sending signals to producers and consumers, cannot be overruled.

Government controlled prices require a protracted research and consideration period, and, once set, cannot be quickly or spontaneously adjusted to meet changing market circumstances. Price controls distort the pricing mechanism and interrupt the dynamic demand and supply process. A common misconception is that healthcare is, somehow, different from other products and that government is justified in limiting profits by introducing price controls. For those people who believe that healthcare markets do not work, why would they think that *any* other market works? Why are they not recommending that government should set the prices for all goods and services?

The market for medical services and other health-related products are subject to the same laws of economics as any other good or service. Food is more important than medicines for human survival, yet government removed price controls on agricultural products when they recognised their damaging effect on the economy and the harm caused to consumers.

History, and basic economics, has repeatedly demonstrated that price controls result in shortages – why then do government officials act surprised when their ill-considered but well-intentioned policies

[26] Hoexter, C. *Administrative Law in South Africa*. (2012). 344.
[27] Hoexter 340.

deliver the exact consequences predicted by basic economic theory? Price controls, especially those that are fixed for protracted periods of time, are squeezing the profit margins of service providers to unsustainable levels because they prevent them from increasing prices when unavoidable input costs rise.

Price control is a complete departure from sound economic policy and has consistently led to harmful consequences for the most vulnerable individuals in society. There is no reason to believe that it will be any different this time. Attempting to control the price of any good or service from a position of force, rather than by making use of ordinary market forces, causes irreparable harm to consumers. In the absence of controls, consumers have the power to punish or reward providers based on the quality of their performance. This applies at every stage of the production and consumption process, and applies to ordinary 'civilian' consumers as well as large corporate or state consumers.

The pricing function is one of the most important roles the market fulfils in society. It sends 'signals' to buyers and sellers and can be traced back all the way to the natural resources used to produce the end product. As consumer tastes and needs change on a continuous basis, demand for particular products rise and fall, which, in turn, causes prices to fluctuate accordingly. These are the signals that alert manufacturers to adjust the supply of a product.

The NDoH has taken an irrational and highly confrontational stance toward private healthcare providers. The idea that a Committee could possibly have the necessary knowledge to determine prices in the market is highly presumptuous. As the late Nobel prize winning economist Friedrich Hayek noted, "The curious task of economics is to demonstrate to men how little they really know about what they imagine they can design".

Conclusion

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, a past 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, most South Africans would choose to go to a private health care facility. Already, a significant amount of out-of-pocket healthcare expenditure occurs 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. The biggest obstacles preventing medical schemes from rolling out options for low-

income individuals, however, 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 but let them 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. It should be noted that spending in one area of the economy necessarily comes at the expense of other areas. In other words, if the government decides to dedicate more of the budget towards healthcare, this necessarily means there is less money available for education, policing, housing etc. In order to fulfil this task (of acting as financier) the 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.

Prepared by:
Jasson Urbach

Free Market Foundation, Director

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