THE FW DE KLERK FOUNDATION

Upholding South Africa's National Accord

Portfolio Committee on Health
Parliament
Cape Town

Attention: **Ms Vuyokazi Majalamba**
Per email: vmajalamba@parliament.gov.za

29 November 2019

Submission on the *National Health Insurance Bill* [B11-2019] ("NHI Bill")

1. The FW de Klerk Foundation (the Foundation) is a non-profit organisation dedicated to upholding the Constitution of the Republic of South Africa, 1996 (the Constitution). To this end, the Foundation's Centre for Constitutional Rights (the CFCR) seeks to promote the Constitution and the values, rights and principles enshrined in the Constitution; to monitor developments, including legislation and policy that may affect the Constitution or those values, rights and principles; to inform people and organisations of their constitutional rights and to assist them in claiming their rights. The Foundation does so in the interest of everyone in South Africa.
2. Accordingly, the Foundation endeavours to contribute positively to the promotion and protection of our constitutional democracy. As such, the Foundation welcomes the opportunity to make a concise submission - per the invitation by the Portfolio Committee on Health (the Committee) - on the proposed NHI Bill.
3. In this regard, please find attached our submission for the Committee's attention and consideration.
4. It is not the purpose or intention of this submission to provide a comprehensive legal analysis or technical assessment of the NHI Bill, but rather to draw attention to certain key concerns in relation to the NHI Bill.
5. We trust that our submission will be of assistance in guiding the Committee in its deliberations regarding the NHI Bill and we are also available to make an oral submission to the Committee.

Yours sincerely,

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Manager: Centre for Constitutional Rights

FW de Klerk (Chairman *Emeritus*), DW Steward (Chairman)
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1. INTRODUCTION: THE FOUNDATION'S APPROACH TO THE BILL

1.1. The Preamble of the Bill provides that the Bill aims to make progress "*towards achieving Universal Health Coverage*" (UHC) through the establishment of a National Health Insurance Fund (NHI Fund) as a health financing system.

1.2. Clause 2 of the Bill provides that the NHI Fund will serve as the "*single purchaser and single payer of health care services*". The Fund will accordingly pool funds for the "*strategic purchasing of health care services, medicines, health goods and health related products from accredited and contracted health care service providers*" to ensure the "*equitable and fair distribution*" of healthcare services.

1.3. The Preamble of the NHI Bill also holds that the proposed NHI Fund will give effect to the State's constitutional duty to provide access to healthcare services to everyone in South Africa in terms of section 27(2) of the Constitution. Section 27(2) of the Constitution states that - ***"****The State must take reasonable legislative and other measures, within its available resources, to achieve the progressive realisation of each of these rights."*

1.4. From the outset, the Foundation wishes to clearly state that it is fully in support of the pursuit of UHC, defined by the World Health Organisation (WHO) as - "*ensuring all people have access to needed health services (including prevention, promotion, treatment, rehabilitation and palliation) of sufficient quality to be effective while ensuring that the use of these services does not expose the user to financial hardship".*[1] (own emphasis)

1.5. The Foundation, however does not believe that the proposed NHI Fund is the only means to achieve this noble goal. The urgent need to find workable solutions to address the stark inequality in healthcare services and to achieve UHC in South Africa, cannot and should not hinge on the feasibility of the NHI Fund.

1.6. To this end the Foundation analysed key failures of the NHI Bill, under the broad themes of the constitutional principle of the Rule of Law and rationality, public participation in the legislative process, and importantly, governance concerns coupled with the unfettered power of the Minister of Health ("the Minister").

1.7. The Foundation also briefly analysed the potential undue impact of certain provisions of the NHI Bill on rights in the Bill of Rights, such as the right to freedom of association in terms of section 18 of the Constitution.

1.8. The Foundation hopes that the Committee will be convinced that an apolitical approach should be adopted in order to find a solution to the critical state of healthcare services in South Africa,

[1] See https://www.who.int/health_financing/universal_coverage_definition/en/, for clarity on the definition of UHC.

and the need to analyse different models to achieve UHC. In support of this approach, the Foundation, in conclusion, briefly expands on the approach adopted by Ireland in this regard.

2. ANALYSIS OF THE PROVISIONS OF THE NHI BILL

2.1. The Rule of Law: The Need for Legislative Clarity

2.1.1. A foundational value of the Constitution is the Rule of Law, which at its core excludes arbitrary power and guarantees equality before the Law.[2] The Rule of Law also importantly requires legislation and rules to be devoid of vagueness.

2.1.2. The Constitutional Court in *Bertie van Zyl (Pty) Ltd and Another v Minister for Safety and Security and Others,*[3] held that the Rule of Law requires Statutes and Rules to be "...*articulated clearly and in a manner accessible to those governed by the rules*."[4]

2.1.3. In the matter of *Affordable Medicines Trust and Others v Minister of Health and Another*[5] (the Affordable Medicines judgment) the Constitutional Court expanded on the doctrine of vagueness and held that - "*The doctrine of vagueness does not require absolute certainty of laws. <u>The law must indicate with reasonable certainty to those who are bound by it what is required of them so that they may regulate their conduct accordingly</u>*".[6] (own emphasis)

2.1.4. Not only should proposed legislation be clearly articulated to provide "*reasonable certainty*" but in order to adhere to the Rule of Law, legislation should also exclude "unpredictability" as the Constitutional Court held in *Van der Walt v Met Cash Trading Limited.*[7]

2.1.5. It is submitted that the NHI Bill contains various provisions that are vague. It is unclear to what extent some of the provisions will apply to members of the public, which is in contradiction to the Rule of Law, as discussed above. There has to be "*reasonable certainty*" of the impact of the provisions of the NHI Bill and it cannot simply be a matter that will be expanded on in further regulations.

2.1.6. A glaringly vague aspect of the NHI Bill is the role of Medical Schemes and to what extent a person, currently a member of such a scheme, will still be covered for healthcare service benefits he or she currently enjoys. In terms of clause 33 of the NHI Bill, Medical Schemes will only be able to offer "*complementary cover*", with no information on what this could entail. No information is currently available on the types of healthcare service benefits to

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[2] *Van der Walt v Met Cash Trading Limited* 2002(4) SA317 at paragraph 65.
[3] 2010(2) SA 181(CC).
[4] At paragraph 21 of the judgment.
[5] 2006(3) SA 247(CC).
[6] At paragraph 73 of the judgment.
[7] See footnote 2 for full case reference.

be provided by the NHI Fund.[8] It is also unclear whether a person will therefore be obliged to register as a user with the NHI Fund to receive the healthcare services that the person's Medical Scheme is prohibited from covering. This, as will be discussed further below, could consequently impact on a person's constitutional rights.

2.1.7. In terms of clause 49(2)(a) of the NHI Bill, the NHI Fund is proposing a mixture of income sources, including reallocating funding for medical scheme tax credits paid to medical schemes to NHI, a payroll tax and a surcharge on personal income. No evidence has been provided by the Department of Health (the Department) on how this proposal will impact current Medical Scheme members, which is a critical failure, considering the number of individuals that belong to Medical Schemes. According to the *Statistics South Africa General Household Survey 2018,* the number of individuals covered by Medical Schemes increased from 7.3 million in 2002, to 9.4 million in 2018.[9]

2.1.8. A further glaringly vague aspect is the role of the District Health Management Office (DHM Office) established in terms of clause 36 of the NHI Bill. The DHM Office is to be established as a national government component in terms of section 31A of the *National Health Act*. The Office must "*manage, facilitate, support and coordinate the provision of primary healthcare services and non-personal health services at district level*". It is also critical to know how the DHM Office will interact with provincial health departments, since health services - in terms of Schedule 4A of the Constitution - are a functional area where both the National and Provincial Legislature have concurrent legislative competence.

2.2. **The Impact of Lack of Information on Public Participation in the Legislative Process**

2.2.1. In addition to the vagueness of several crucial provisions of the NHI Bill, one must also ask to what extent is the public able to engage meaningfully with the provisions of the NHI Bill, considering the lack of critical information provided on its implications?

2.2.2. Public participation in the legislative process is a cornerstone of our constitutional democracy and in *Doctors for Life International v Speaker of the National Assembly and Others*[10] (Doctors for Life judgment) the Constitutional Court held that the constitutional duty to facilitate public participation in the legislative process must "... *be understood as a manifestation of the international law right to political participation*".[11]

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[8] Clause 55(1)(x) of the NHI Bill.
[9] See page 26 of Stats SA *General Household Survey* Report, published in May 2019.
[10] 2006(6) SA 416 (CC).
[11] At paragraph 107 of the judgment.

2.2.3. The Doctors for Life judgment also emphasised that this right includes a duty on the State to ensure that citizens have the *"... necessary information and effective opportunity to exercise the right to political participation*."[12] (own emphasis)

2.2.4. Although the public has been provided with the opportunity to make submissions on the NHI Bill, we submit that there is reasonable "necessary information" glaringly absent from the NHI Bill. This omission not only deprives the public of the opportunity to meaningfully engage with its content, it also importantly deprives the public of the means to test the rationality of the measures proposed.

2.2.5. These glaring gaps in "necessary information" required for meaningful public participation will now be discussed separately in relation to the question of the rationality of the ambitious project.

2.3. **Rationality of NHI Questioned:**

2.3.1. **Rationality of Measures Considering Lack of Information on Financial Feasibility of NHI**

2.3.1.1. The Rule of Law principle - as defined earlier - requires that the exercise of public power should not be arbitrary. Inherent in this requirement is that decisions must be rationally related to the purpose for which the power was given.[13]

2.3.1.2. It cannot simply be stated that the goal of NHI is to ensure UHC and that the objective rationally satisfies the measures adopted. The public has a right to reasonable "necessary information" to test whether the ambitious project is rationally related to the information considered. As stated above, this is also critical to ensure meaningful engagement on the content of the Bill and to ensure the public's right to public participation in the legislative process can be effectively fulfilled.

2.3.1.3. In *Minister of Constitutional Development and Another v South African Restructuring and Insolvency Practitioners Association and Others,*[14] the Constitutional Court reiterated that the rationality test requires "*that a measure must be rationally related to the information available to its designer/formulator at the time of making his/her decisions' and 'must bear a rational relationship to its objectives'*".[15] (own emphasis)

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[12] At paragraph 105 of the judgment.

[13] In *Minister of Defence and Military Veterans v Motau and Others 2014(5) SA 69 (CC),* the Constitutional Court at paragraph 69 confirmed that for the exercise of public power to adhere to the principle of legality, it must be rationally related to the purpose for which the power was given.

[14] 2018(5) SA 349 (CC).

[15] At paragraph 8 of the judgment.

2.3.1.4. A critical aspect lacking is details about the costing of the NHI, coupled with lack of information on the implementation plans and healthcare service benefits to be provided.[16]

2.3.1.5. The Memorandum of the NHI Bill, point 8, stipulates the "*financial implications for the State*". It vaguely refers in point 8(1)(c) to an "*Actuarial costing model*" and it highlights that Treasury "*commissioned a simplified intervention-based costing tool for 2019/20 which provides simple estimates of costs of a set of 15 or so interventions*". This full set of interventions will accordingly cost "*in the long term around R30 billion per annum*".[17] (own emphasis)

2.3.1.6. It is however highly concerning that this "*actuarial costing model*", which Treasury appears to have commissioned, is not publicly available or part of the NHI Bill for the public to consider and assess.

2.3.1.7. The affordability of the proposed NHI Fund has been a serious public concern, especially considering South Africa's dire lack of economic growth and the budget deficit.

2.3.1.8. In the Medium-Term Budget Policy Statement (MTB 2019) delivered on 30 October 2019, the Minister of Finance held that - "*South Africa's economic growth is now projected at 0.5 percent for 2019 ... Spending pressures continue to mount, led by the public service wage bill and state-owned companies in crisis. The combination of lower revenue and increased spending widens the budget deficit to an average of 6.2 percent over the next three years*."[18] (own emphasis)

2.3.1.9. The feasibility of the NHI - considering the above information - must also be measured against the findings of the *Davis Tax Committee Report on the Financing of National Health Insurance*[19] (The Davis Report).

2.3.1.10. The Davis Tax Committee evaluated the NHI White Paper,[20] published by the Department of Health on 15 December 2015 (2015 White Paper) and looked at the various financing proposals. The Davis Report, released in March 2017, also emphasised concerns about lack of detail on costing, implementation plans and healthcare benefits.[21] The Committee held that the R256 billion per annum funding

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[16] Detail of the scope and nature of prescribed healthcare benefits will only become available once regulations are published in terms of clause 55(1)(x) of the NHI Bill.

[17] Point 8(1)(c) of the Memorandum on the Objects of the National Health Insurance Bill, 2019.

[18] See: *http://www.treasury.gov.za/documents/mtbps/2019/mtbps/FullMTBPS.pdf* for a copy of the MTB Policy Statement 2019.

[19] Full reference: "*Report on the Financing of a National Health Insurance for South Africa, March 2017*".

[20] *White Paper: Health Insurance for South Africa: Towards Universal Coverage*.

[21] At page 43 of the Report.

increase the White Paper focused on (at 2010 prices), with a funding shortfall of about R72 billion in 2025 (assuming an average growth rate of 3.5%), could "*be substantially more*".[22]

2.3.1.11. The Davis Tax Committee furthermore held that - "*Should the real annual growth rate reach just 2%, then the shortfall could be as large as R108 billion. Should the average growth rate dip below 2% (as is currently the case), then it is likely that even the R108 billion figure could substantially understate the actual shortfall*."[23] (own emphasis)

2.3.1.12. There is no indication in the Memorandum of the Bill that any consideration has been given to the findings of the Davis Report.

2.3.1.13. The public currently only has the NHI White Papers' NHI expenditure projections to evaluate - which refer to 2010 prices. There have been no updated projections provided to the public considering the current annual growth rate of only 0.5%, as evidence by the Minister of Finance's MTB 2019, or updated prices since 2010, now almost 10 years ago.[24]

2.3.1.14. The above glaring failure also directly questions the rationality of the ambitious NHI project. The public has not been provided with this vital information to test the rationality of the proposed measures contained in the NHI Bill, which is a critical failure. As stated earlier, the rationality test not only requires a rational relationship between the objective and the measure, the measure adopted or proposed should also be rationally related to the information considered at the time.

2.3.1.15. We also submit that it is misleading to maintain - as the Department does in the 2017 NHI White Paper - that the WHO stated that although "*costing assumptions and scenarios may be useful for raising core policy issues regarding the sustainability of reforms, it is not useful to focus on getting the exact number indicating the estimated cost*" and that "*focusing on the question of 'what will the NHI cost' is the wrong approach…*".[25] (own emphasis)

2.3.1.16. The WHO brief referred to in the 2017 NHI White Paper in fact clearly says "*costing scenarios and assumptions may be valuable for raising some core policy issues. The*

[22] At page 43 of the Report.

[23] At page 43 of the report.

[24] The NHI Expenditure scenarios in both the *2017 NHI White Paper: National Health Insurance for South Africa: Towards Universal Health Coverage* (published on 28 June 2017) and the 2015 NHI White Paper considered by the Davis Tax Committee are the same. The NHI expenditure scenarios in the 2017 NHI White Paper can be found on page 39-40 and in the 2015 version also on pages 39-40.

[25] At paragraph 200 of the 2017 NHI White Paper. See note 19 above for full reference of the White Paper.

process thus brings to the surface key choices and implementation issues...".[26] No key choices, substantiated by different costing scenarios, have been presented to the public to consider rationally and apply their minds as to what potential funding model would best achieve UHC.

2.3.1.17. It is further submitted that the public has a right to know how the financial implications of the NHI will impact on other State programmes, such as basic and tertiary education, or social security.

2.3.1.18. The Davis Report specifically held that the "... *magnitudes of the proposed NHI fiscal requirements are so large that they might require trade-offs with other laudable NDP programmes such as expansion of access to post school education or social security reform*."[27] The Davis Tax Committee also concluded that "... *the current costing parameters outlined in the White Paper, the proposed NHI, in its current format, is unlikely to be sustainable unless there is sustained economic growth."*[28]

2.3.1.19. It is therefore submitted that for the public to engage meaningfully with the provisions of the NHI Bill and to test the rationality of the measures proposed, updated NHI expenditures and costing projections - at the bare minimum - are needed. Details on the healthcare service benefits and types of services to be reimbursed and the prices of these benefits must also be provided. This information cannot be made available to the public only in future regulations to be published by the Minister in terms of clause 55(1)(x) of the NHI Bill.

2.3.1.20. It would have been rational to already have established the Benefits Advisory Committee and Health Care Benefits Pricing Committee (as proposed in clauses 25 and 26 of the NHI Bill) to allow them to start working on these determinations in the first NHI phase (extending from 2012/13 - 2016/17) so that these crucial details could have been part of the content of the NHI Bill.[29]

2.3.2. **Rationality of Proposed Measures Considering Lack of Information on Pilot Projects**

2.3.2.1. It is also concerning that the Memorandum of the NHI Bill makes no reference to the results of the pilot phase of the NHI. The public is left in the dark as to how the Department will use the results of the NHI pilot phase to inform the next phases.

[26] See the WHO brief at: *https://www.afro.who.int/news/costing-health-care-reforms-move-towards-universal-health-coverage-uhc-considerations-national.*
[27] At page 44 of the Report.
[28] At page 44 of the Report.
[29] In terms of the 2017 NHI Bill, the first phase was from 2012-2017, which included piloting of healthcare initiatives.

2.3.2.2. Considering the magnitude of this ambitious proposal, this failure is a glaring omission.

2.3.2.3. From the 2015 NHI White Paper, we know that the pilot phase extended from the 2012/13 to the 2016/17 financial year, and that this phase "*include[d] various activities in preparation for the full implementation of NHI. Part of this work includes the strengthening of the health system…*".[30] (own emphasis)

2.3.2.4. A final evaluation report of the NHI Phase 1, conducted by a consortium led by Genesis Analytics, only became available to the public in July 2019[31] (Genesis Report).

2.3.2.5. From the executive summary of the Genesis Report it appears that it was difficult to evaluate the overall impact of the implementation of the interventions due to various factors, such as lack of control groups. The Report submitted that it was difficult to *"...identify clear trends in performance over time."*[32] The public is therefore no further in knowing whether the interventions are in fact working.

2.3.2.6. There are also deeply concerning findings in the Genesis Report, which require a plan of action from the Department, such as the fact that projects relating to the intervention measure "Infrastructure" were "*rarely implemented or completed due to lack of planning capacity to release the assigned funds*" and the maintenance of facilities received insufficient attention.[33]

2.3.2.7. Despite the Genesis Report specifically recommending that there is a "*need to strengthen health system governance during NHI Phase 2*"[34] there is no mention in the NHI Bill or accompanying Memorandum of how these recommendations will be implemented.

2.3.2.8. In fact, clause 57 of the NHI Bill concerning "*Transitional arrangements*" creates confusion as it does not acknowledge the pilot phase (described as Phase 1 in the NHI White Papers). Clause 57(2)(a) of the NHI Bill, describes Phase 1 to be from 2017 to 2022, and Phase 2 to be from 2022 to 2026, in terms of clause 57(2)(b). Clause 57(2)(a)(i) merely states that there must be a continuation "*with the implementation of health system strengthening initiatives…"*.

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[30] At page 83.

[31] Full reference: "*Evaluation of Phase 1 Implementation of interventions in National Health Insurance (NHI) pilot districts in South Africa. NDOH 10/2017-18. Final Evaluation Report July 2019*".

[32] At page 16 of the Report.

[33] At page 15 of the Report.

[34] At page 16 of the Report.

2.3.2.9. Again, the above approach by the Department brings into question the rationality of the proposed NHI, as it appears that the Department is blindly bulldozing ahead with the proposal, without due consideration of the results of the NHI pilot phase.

2.3.3. **Rationality of Potential Restrictions on Medical Professions**

2.3.3.1. Below, at section 2.5 of our submission, we specifically raised concerns on potential infringements of provisions of the NHI Bill on rights in the Bill of Rights.

2.3.3.2. In our analysis of the potential impact of the provision of a "*national pricing regime*" on a healthcare provider's constitutional right to freedom of trade, occupation and profession, we submitted that the lack of information on what the proposed "*national pricing regime*" would entail - and hence the extent of regulation of an individual's professional career - also brings the rationality of the proposal into question.[35]

2.3.3.3. The rationality argument in this specific instance is further fleshed out under section 2.5 of our submission but again it also speaks to the extent the public is denied the opportunity to meaningfully engage with the content of the NHI Bill.

2.4. **Governance Concerns: Minister of Health's Unfettered Power**

2.4.1. In the Constitutional Court judgment of *United Democratic Movement v Speaker of the National Assembly and Others*[36] (UDM matter), the Chief Justice emphasised that - "*South Africa is a constitutional democracy - a government of the people, by the people and for the people through the instrumentality of the Constitution. It is a system of governance that 'we the people' consciously and purposefully opted for to create a truly free, just and united nation. Central to this vision is the improvement of the quality of life of all citizens and the optimisation of the potential of each through good governance*."[37] (own emphasis)

2.4.2. The Chief Justice in the UDM matter reiterated that for good governance there must be a separation of powers between the Legislature, Executive and Judiciary, and that there must be "*appropriate checks and balances to ensure accountability, responsiveness and openness*."[38]

2.4.3. Central to the evaluation of the feasibility of the proposed NHI Fund is the question of good governance and whether enough checks and balances are built into the NHI Bill to limit abuse of power and to ensure "*accountability, responsiveness and openness*".

2.4.4. It is also important to realistically take stock of the mammoth task the NHI Fund has been assigned. Not only will the NHI Fund be responsible for purchasing all healthcare services

[35] See clause 39(2)(b)(vi) and 39(8)(g).
[36] 2017(5) SA 300 (CC).
[37] At paragraph 1 of the judgment.
[38] At paragraph 2 of the judgment.

on behalf of all 'users', determining payment rates for healthcare service providers, and establishing payment mechanisms to healthcare service providers and healthcare establishments but it will also be responsible for research and evaluation of the impact of the Fund on "*national health outcomes*".[39]

2.4.5. The question of appropriate checks and balances is even more critical considering the dire financial state of South Africa's State-Owned Enterprises (SOEs)[40] and the well-recorded evidence of patronage networks, which led to the large-scale looting of State resources at key SOEs and 'State capture' in South Africa.[41]

2.4.6. In the President's State of the Nation Address of 20 June 2019, it was emphasised that the State is "*committed to building an ethical state in which there is no place for corruption, patronage, rent-seeking and plundering of public money*".[42] However, despite these promises, the NHI Bill currently provides ample opportunity for patronage and corruption, as indicated below:

2.4.6.1. In terms of clause 9 of the Bill, the NHI Fund is established as an "*autonomous public entity*" in terms of Schedule 3A of the *Public Finance Management Act* 1 of 1999 and the Board of the NHI Fund, in terms of clause 12, is <u>only accountable</u> to the Minister. This is a regression in oversight over the functions of the Board of the NHI Fund. In the draft version of the NHI Bill, published by the Minister on 21 June 2018,[43] the NHI Fund Board was described as "*an independent board*" (2018 NHI Bill) and it was explicitly stated that the Board was "*accountable to Parliament*" and not to the Minister.[44] No justification has been provided for this regression in oversight.

2.4.6.2. The above situation is aggravated by the extensive powers that the Minister (a member of the Executive and a political appointee *per se*) alone holds in relation to the functioning of the NHI Fund.

2.4.6.3. In terms of clause 13(1), the Board of the NHI Fund may not consist of more than 11 persons to be appointed by the Minister, one of which must represent the Minister.

2.4.6.4. Although clause 13(2) of the NHI Bill provides that the Minister must call for public nominations of candidates to serve on the Board and that an *ad hoc* advisory panel

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[39] Clause 10(1)(a)-(u) of the NHI Bill provides for the extensive list of functions of the NHI Fund to be established.

[40] See - *https://www.fin24.com/Economy/worst-audit-outcomes-ever-for-soes-20191120.*

[41] See the research paper "*Betrayal of the promise: How South Africa is being stolen*" published by the State Capture Research Project in May 2017. The State Capture Research Project was an interdisciplinary and inter-university research partnership.

[42] See - *https://www.gov.za/speeches/2SONA2019*

[43] *National Health Insurance Bill* [B-2018] published in Government Notice 635 in *Government Gazette* 41725 of 21 June 2018.

[44] Clause 13 and 16(1) of the NHI Bill[X-2018].

must, in terms of clause 13(3), conduct interviews and forward their recommendations to the Minister, glaring gaps remain, providing opportunity for political interference.

2.4.6.5. No qualifying criteria is provided for the members sitting on the *ad hoc* advisory panel conducting the interviews, and these members are again only appointed by the Minister.

2.4.6.6. Guidance on measures to restrict political interference in the above instance are well provided for in the *Commission of Inquiry into Tax Administration and Governance by SARS Final Report* (Nugent Report).[45]

2.4.6.7. The Nugent Report recommended that the members on the interview panel (appointed by the President to conduct interviews and submit a shortlist for the President to consider in the appointment of the Commissioner of SARS) should be "*apolitical and not answerable to any constituency and should be persons of high standing…*".[46] No such criteria exist for members sitting on the *ad hoc* advisory panel tasked with the important responsibility of making recommendations to the Minister on Board Members to manage the ambitious NHI Fund.

2.4.6.8. Furthermore, it is not clear in terms of clause 13(3) of the NHI Bill who will decide on the "shortlisted candidates" to be interviewed by the *ad hoc* advisory panel, and no criteria is provided in this clause to guide the interview panel in its deliberations. The Nugent Commission Report also recommends that clear criteria should be provided to an interview panel to measure the candidates against.[47]

2.4.6.9. The qualification requirements for the members of the Board of the NHI Fund in terms of clause 13(5) of the NHI Bill also need to be strengthened to provide stricter criteria to prevent political interference in the managing of the NHI Fund. The criteria need to be more objectively determinable.

2.4.6.10. A requirement such as a "*fit and proper person*" in terms of clause 13(5)(a) of the NHI Bill has been the centre of many court cases, as no definition is provided for in legislation and there has always been the risk of subjective interpretation on application. It is recommended - in line with the Constitutional Court's interpretation of a "fit and proper" person in *Democratic Alliance v President of South Africa and Others*[48] - that it should be clear that it is not a "*subjective determination*" and even

[45] See - *http://www.thepresidency.gov.za/report-type/commission-inquiry-tax-administration-and-governance-sars.*
[46] See paragraph 16.3.4 on page 198 of the Report.
[47] See page 187 of the Nugent Commission Report.
[48] 2013(1) SA 248 (CC).

though it is a "*value judgment*" it is an "*objective jurisdictional fact*".[49] The requirement can be strengthened by requiring a Board Member to be "*reputed to be of unblemished integrity*" in line with the Nugent Report's recommendations.[50]

2.4.6.11. Furthermore, the requirement that Board Members should have the "*appropriate technical expertise, skills and knowledge or experience*" in terms of clause 13(5)(b) of the NHI Bill should be strengthened. Considering the mammoth task of managing the NHI Fund, a Board Member should at the very least have proven experience in managing a large organisation or big projects in the stipulated fields.

2.4.6.12. The Minister also has the sole power to remove a member of the Board of the NHI Fund in terms of clause 13(8), with no oversight from Parliament, which again provides opportunity for political interference.

2.4.6.13. Further centralisation of power in the hands of the Minister is seen with the appointment of the Chief Executive Officer (CEO) of the Board of the NHI Fund in terms of clause 19, and the appointment of members of the various advisory committees, such as the Benefits Advisory Committee, the Health Care Benefits Pricing Committee, the Stakeholder Advisory Committee and the appointment of members of the Appeal Tribunal.[51]

2.4.6.14. These Advisory Committees play critical roles, such as determining the scope of healthcare service benefits to be provided and the prices of these healthcare service benefits to the NHI Fund. Members of these three Advisory Committees in Chapter 7 of the NHI Bill are all appointed by the Minister after consultation with the Board of the NHI Fund, with no involvement by Parliament in nominating members of these Committees.[52] There is therefore no direct or indirect public participation in the nomination process.

2.4.6.15. The Chairpersons of these Advisory Committees are again all appointed by the Minister alone. The Minister has the sole power in terms of clause 30(b) to terminate a person's membership to one of these Advisory Committees for "*adequate reason*", with no objective oversight of this determination.[53]

2.4.6.16. The members of the Appeal Tribunal in terms of clause 44 of the Bill, consisting of five persons, are also all appointed by the Minister alone and the Minister has the sole

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[49] See paragraphs 20 and 23 of the judgment.

[50] At page 187 of the Nugent Commission Report.

[51] These Advisory Committees are to be established in terms of Chapter 7 of the Bill. The Appeal Tribunal is established in terms of clause 44 of the Bill.

[52] See clause 25(2), clause 26(1) and clause 27(1) of the Bill.

[53] Chairpersons of these Advisory Committees are appointed in terms of clause 25(6) and clause 26(4).

power in terms of clause 44(3)(b) to terminate a person's membership on the Appeal Tribunal.

2.4.6.17. The above provisions providing extensive power to the Minister are further aggravated by the fact that very little regard is given to anti-corruption measures in the NHI Bill.

2.4.6.18. Clause 20(2)(e) merely states that the CEO must establish an Investigating Unit within the national office of the Fund to investigate fraud and corruption complaints. The independence of such a unit is seriously questionable, as it appears that it will directly report to the CEO - providing very little reassurance that it will be immune against patronage.

2.4.6.19. The *Presidential Health Summit Compact: Strengthening the South African Health System Towards an Integrated and Unified Health System*[54] (the Health Compact) signed by the President on 25 July 2019, unequivocally acknowledged that both the public and private health sectors are highly vulnerable to fraud and corruption. The Health Compact states that this appears to be due to the large number of transactions on goods and services, tender irregularities, poor governance and over-pricing.

2.4.6.20. The Health Compact specifically recommended that a whistle-blowing policy should be developed to ensure ease of reporting and that "*political interference should be considered as a corrupt activity*."[55]

2.4.6.21. Even though a Health Sector Anti-Corruption Forum was established in September 2019 following the release of the Health Compact, it is concerning that the NHI Bill, which appears to have been rushed through Parliament, does not make any reference to these suggestions to curb corruption and fraud in the Health Sector.[56]

2.4.6.22. The provision of adequate checks and balances in the NHI Bill, curbing corruption, fraud and patronage and ensuring good governance should be a high priority. This is especially so considering the alarming reports from the Auditor-General (AG) on the dire financial status of provincial health departments, such as the Free State Health Department, which was reported to have lost R101 million in the 2018-19 financial year.[57]

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[54] Full citation: "South African Government: Strengthening the South African health system towards an integrated and unified health system, Presidential Health Summit Compact, 25 July 2019."

[55] See page 66 of the Health Compact.

[56] The Health Sector Anti-Corruption Forum was launched by the President on 1 October 2019 according to a press statement issued by the Presidency.

[57] See the AG's media report of 20 November 2019 on the audit results of provincial and national government.

2.5. **Impact of Provisions in the NHI Bill on Rights in the Bill of Rights and Constitutional Concerns**

2.5.1. **Potential Impact on an Individual's Right to Freedom of Association and Interrelated Rights**

2.5.1.1. Clause 33 of the NHI Bill provides that the role of Medical Schemes will be restricted to only "*complementary cover to services not reimbursable by the Fund*" once the NHI has been fully implemented. We submit, this clause could be read as compelling a member of a Medical Scheme to register in terms of the NHI Act so that they could use the healthcare services provided by the NHI, as their Medical Scheme will not be allowed to provide coverage for these services.

2.5.1.2. In terms of clause 8(2)(b) of the NHI Bill, a person will be obliged to pay for the healthcare services if they "*fail to comply with referral pathways prescribed by a health care service provider or health establishment*". On our reading of this provision, it appears that if a person refuses to use the NHI referral pathways to see a specialist (as one cannot directly approach a specialist) his or her Medical Scheme may cover these costs. However, this arguably does not appear to be (at least) the case with primary healthcare services.

2.5.1.3. Members of Medical Schemes (who are currently covered for primary healthcare services in terms of the *Medical Schemes Act* 131 of 1998) will indirectly be forced - on our reading - to register in terms of the proposed NHI Act in order to access these services. As no detail is provided on the meaning of "*complementary cover*", it is not possible to say which level of healthcare services will be restricted. However, on our understanding, this at a minimum could exclude the cover of primary healthcare services.

2.5.1.4. Clause 33 of the NHI Bill brings into question the potential infringement on the right of a person to freedom of association, guaranteed in terms of section 18 of the Bill of Rights in the Constitution.

2.5.1.5. The South African legal scholars Ian Currie and Johan de Waal have held that there are four "*fundamental justifications*" for the right to freedom of association. One of the relevant justification grounds is that the right to freedom of association "*prevents the State and other powerful social actors from determining the most basic contours of our lives through coercion*".[58] (own emphasis)

2.5.1.6. The choice of healthcare services and where and how to access these services could be argued to be interrelated with the constitutional right to "*bodily and*

[58] *The Bill of Rights Handbook*, 5th Edition. Ian Currie & Johan de Waal on page 420.

psychological integrity", which includes the right of a person to be in *"security in and control over their body*" in terms of section 12(2)(b) of the Constitution.

2.5.1.7. The State, by potentially forcing mandatary registration of people to become users of the NHI Fund, as their Medical Schemes are denied from providing coverage for these healthcare services, is potentially infringing on "*the most basic contours*" of a person's life "*through coercion*".

2.5.1.8. One would need to determine whether the <u>means adopted</u> to achieve UHC (and to give effect to section 27 of the Constitution) justify the limitation of the rights to freedom of association and to a degree, to a person's right to bodily integrity, by weighing up the different factors in section 36(1) of the Constitution (section 36 limitation analysis).

2.5.1.9. We, however, submit that currently it is factually impossible to do the section 36 limitation analysis as no detail has been provided on "*complementary cover*" or the type of healthcare service benefits the NHI Fund will cover. Information on these aspects are critical to determine "*the nature and extent of the limitation*" and "*the relation between the limitation and its purpose*" in terms of section 36(1)(c) and (d) of the Constitution.

2.5.1.10. Furthermore, the limitation can only be properly analysed if information has been provided on alternatives to achieve UHC. One would then be able to determine whether "*less restrictive means*" are available in terms of section 36(1)(e) of the Constitution to achieve this purpose.

2.5.1.11. Currently the vagueness of the provisions and lack of detail potentially reflect an overbroad limitation on the rights to freedom of association and bodily integrity.

2.5.1.12. Related to the potential impact on a person's right to freedom of association is the reality of the pressure that will be placed on healthcare facilities (private and public) to meet the demands of the NHI. The Office of Health Standards Compliance (OHSC) in their *2016/17 Annual Inspection Report* on public health facilities, provided little assurance of the ability of public healthcare facilities to be fully accredited by the OHSC to deliver services to the NHI in the anticipated timeframe. Of the 696 public health establishments visited by the OHSC, public hospitals only received an average score of 59% nationally.[59]

2.5.1.13. This pressure could inevitably lead to longer waiting time to receive healthcare services, questioning again the reasonability of limiting coverage by Medical

[59] See page 5 of the OHSC's Inspection Report.

Schemes for such services and limiting a Medical Scheme member's right to freedom of association.

2.5.1.14. In a ground-breaking 2005 judgment by the Supreme Court in Canada in *Chaoulli v Quebec (Attorney General),*[60] (Quebec judgment) the above issues were specifically at stake.

2.5.1.15. The Supreme Court in the Quebec judgment found that Quebec provincial legislation prohibiting residents from taking out insurance to obtain private sector healthcare services already available under Quebec's Public Healthcare Plan[61] was an undue limitation of the rights to life and personal inviolability protected in terms of section 1 of the *Quebec Charter of Human Rights and Freedoms*.

2.5.1.16. A key aspect in the Quebec judgment was that their argument was based on the unreasonable waiting time for certain surgical procedures under the Public Healthcare Plan, which made the limitation of private healthcare for these procedures unreasonable.

2.5.1.17. Although the Quebec judgment is foreign law, which the Committee is not obliged to consider but "may consider" in terms of section 39 of the Bill of Rights, we submit it does raise important considerations for the South African context, when analysing the potential impact of the NHI Bill on the rights to bodily integrity, freedom of association and inevitably, Medical Scheme members' right to access healthcare services in terms of section 27(1) of the Constitution.

2.5.2. **Potential Impact on An Individual's Right to Freedom of Trade, Occupation and Profession**

2.5.2.1. We further submit that a person's right to freedom of trade, occupation and profession in terms of section 22 of the Constitution, also comes into question upon analysis of the NHI Bill.

2.5.2.2. Section 22 of the Constitution provides that "*Every citizen has the right to choose their trade, occupation or profession freely. The practice of a trade, occupation or profession may be regulated by law."*

2.5.2.3. The Constitutional Court in the Affordable Medicines judgment also gave insight on how section 22 of the Constitution should be analysed. The Court held that that "*there are two components to this right: it is the right to choose a profession and the*

[60] *Chaoulli v Quebec (Attorney General),* [2005] 1 S.C.R. 791, 2005 SCC 35.

[61] In specific, section 15 of the *Health Insurance Act, R.S.Q., c. A-29* and section 11 of the *Hospital Insurance Act, R.S.Q., c. A-28.*

right to practise the chosen profession. This is implicit, if not explicit from the text of section 22."[62]

2.5.2.4. If the law regulating a profession would negatively impact the choice of a profession, then the law must be considered under section 36 of the Constitution. If the law regulating a profession does not negatively impact on the choice of a profession then it must be viewed in terms of section 22 of the Constitution, meaning it is a less stringent test, but it is still subject to the rationality test.[63]

2.5.2.5. The above approach was confirmed in *South African Diamond Producers Organisation v Minister of Minerals and Energy N.O. and Others*[64] in which the Constitutional Court held - "*restrictions on the right to practise a profession are subject to a less stringent test than restrictions on the choice of a profession*" but the measure still has to pass the rationality test.[65]

2.5.2.6. Clause 39(2)(b)(vi) of the NHI Bill, stipulates that a "*health care service provider*" must adhere to "*the national pricing regimen for services delivered*" in order to be accredited by the NHI Fund. The NHI Fund may also withdraw or refuse accreditation of a healthcare service provider if they fail to adhere to the "national pricing regime" in terms of clause 39(8)(g) of the NHI Bill.

2.5.2.7. The question is whether the above provisions could mean that a general healthcare practitioner, for instance, could be compelled to provide his or her services at a fixed NHI predetermined rate, regardless of where he or she practices? Would such a restriction on the profession satisfy the rationality test?

2.5.2.8. We reiterate again that it is critical to provide information to the public on the meaning of a "*national pricing regime*" in order to determine whether this measure would satisfy the rationality test.

2.5.2.9. On this aspect, it is important to also ask how the recommendations made by the Competition Commission in their *Health Market Inquiry* (Health Market Inquiry Report) into the private health sector could interact and inform these proposals in the NHI Bill.[66]

2.5.2.10. The Health Market Inquiry Report released in September 2019 recommended the establishment of an independent "*supply side regulator for health authority"*. It is

[62] At paragraph 63 of the Affordable Medicines judgment.
[63] See paragraph 68 of the Affordable Medicines judgement.
[64] 2017(6) SA 331 (CC).
[65] At paragraph 65 of the judgment.
[66] See - http://www.compcom.co.za/healthcare-inquiry/.

our understanding that under this Supply Side Regulator a "*multilateral negotiation forum*" is envisioned, providing Medical Schemes and Health Practitioners with a platform to reach consensus on tariffs - all with the aim to provide "*competitively priced services*". It is envisioned that these negotiations will lead to a national maximum "*Fee-for-Service*" tariff for 'Prescribed-Minimum Benefits (PMB) conditions' and a 'reference tariff' for non-PMB conditions. This consensus-seeking approach appears to be much more reasonable and desirable.

2.5.2.11. We submit that considering the potential impact on section 22 of the Constitution, the public has a right to know what information will be considered to determine the "*national pricing regime"* and whether the recommendations in the Health Market Inquiry Report will inform this regime. Without these details one cannot evaluate the rationality of the proposed measures.

2.5.2.12. Research done in 2018 by the Trade Union, Solidarity, relying on surveys filled in by participants practicing in the healthcare sector, indicated that 48.8.% felt that they were not well-informed about the NHI. Only 38.3% of the General Practitioners who completed Solidarity's survey felt that they had "*sufficient knowledge of the NHI*" and 83.2% of the respondents indicated that they thought that medical professionals, especially in the private sector, would leave the country under the NHI. This survey, despite being restricted to members of the Trade Union, does provide evidence of perspectives of people working in the health sector on the potential impact of NHI, which cannot simply be dismissed.[67]

2.5.3. **Potential Impact of Bill on Asylum-Seekers' Right to Access Healthcare Services**

2.5.3.1. Lastly, a final concern relates to the impact of the NHI Bill on the rights of asylum-seekers to access healthcare services. We have noted that in terms of clause 4(2) of the NHI Bill, an asylum-seeker is only entitled to "*emergency medical services*" and "*services for notifiable conditions of public concern*". In the 2018 NHI Bill, asylum-seekers were also specifically granted the right to "*paediatric and maternal services at primary healthcare level*".[68] There has been no justification provided for the regression in access to healthcare services for asylum-seekers.

[67] The Report was compiled by Solidarity Research Institute. Full reference - *Solidarity Research Institute "Healthcare worker' knowledge, insight and opinion of the proposed National Health Insurance", N. Welthagen*, August 2018. This research was conducted in July 2018 and the methodology involved a Non-Random convenience sample taken from Solidarity's member database and an electronic questionnaire was sent to 3 983 respondents by email.

[68] Clause 7(1)(c) of the 2018 NHI Bill.

2.5.3.2. It is important to remember the reference to "*everyone*" in section 27 of the Constitution, and therefore the right to access healthcare services, including reproductive healthcare, is not only limited to South African citizens.[69] Although the extension of these healthcare services is dependent on State resources and these rights can arguably be limited in terms of section 36 of the Constitution, this regression in healthcare services is at great odds with South Africa's vision in terms of the *National Development Plan 2030*.

2.5.3.3. South Africa committed to achieve an infant mortality rate of "*less than 20 deaths per thousand live births*" by 2030, which is logically dependant on ensuring adequate paediatric and maternal services at primary healthcare level.[70]

2.5.3.4. South Africa also ratified the *International Covenant on Economic, Social and Cultural Rights* (ICESR) in 2015, which expressly provides that State parties recognise the right of "*everyone to the enjoyment of the highest attainable standard of physical and mental health*" in article 12.

2.5.3.5. In a General Comment published by the Office of the High Commissioner for Human Rights on article 12 of the ICESR,[71] it was emphasised that this obligation, which depends on a State's resources and on an "*individual's biological and socio-economic preconditions*", extends to asylum-seekers.[72]

2.5.3.6. Regression in providing access to these vital healthcare services to asylum-seekers, without any justification, is at odds with South Africa's international law commitments in terms of the ICESR.

2.5.4. Lastly, we submit that it unclear on reading the NHI Bill to what extent the concurrent legislative competence of Provinces in relation to healthcare services will be impacted, which raises constitutional concerns. In terms of Schedule 4A of the Constitution, health services constitute a functional area of concurrent national and provincial legislative competence. Section 146 of the Constitution does provide remedies in the instance where there is conflict between national and provincial legislation, providing specific conditions when national legislation would prevail.

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[69] See *Khosa and Others v Minister of Social Development and Others, Mahlaule and Another v Minister of Social Development 2004(6) SA 505(CC)* at paragraph 47 relating to the meaning of "everyone" in section 27 of the Constitution.

[70] *National Development Plan 2030 - Our future make it work*. See page 330 of the Plan relating to infant mortality.

[71] Office of the High Commissioner for Human Rights. *ICESR General Comment No. 14: The Right to the Highest Attainable Standard of Health (Art. 12).* Adopted at the Twenty-second Session of the Committee on Economic, Social and Cultural Rights, on 11 August 2000 (Contained in Document E/C.12/2000/4).

[72] See paragraph 34 of the General Comment.

2.5.5. One would need to determine to what extent the Provinces still have this concurrent functionality, whether they can deviate, and if the proposed NHI Act is to prevail, it would need to satisfy the specific conditions in terms of section 146(2) or (3) of the Constitution.

2.5.6. It is therefore critical again to provide more information not only on the functioning and interaction of the DHM Offices with the provincial health departments but also on the proposal that the provincial equitable share of the health budget will be shifted to the NHI Fund, to be controlled nationally.

3. CONCLUSION: NHI IS NOT THE SOLUTION

3.1. The Need to Urgently Rebuild the Public Health Sector and Implement Health Market Inquiry Recommendations

3.1.1. Considering the lack of critical information regarding the financial implications of the proposed NHI Fund, the lack of detail on Medical Schemes' coverage and the potential impact on constitutional rights, in addition to serious flaws in providing for checks and balances, we submit that the proposed NHI Bill does not provide the answer to achieve UHC.

3.1.2. If the State is serious about making health reform a high priority, it should urgently work with stakeholders towards implementing the interventions provided for in the Health Compact to improve the public healthcare system.

3.1.3. The State should also urgently attempt to curb the alarming increase in medico-legal claims against provincial health departments. These claims - as the AG pointed out - are not budgeted for and are paid out directly from funds earmarked for the delivery of services, which severely cripples access to healthcare services to the most vulnerable.[73] In 2018-19 alone, the AG held that the Mpumalanga Department of Health's budget for claims was R68 million but the actual claims paid out amounted to R499 million. As a result, vacant positions for a chief executive officer and nurses were not filled.[74] This has a devastating impact on access to healthcare.

3.1.4. Lastly, the Memorandum of the NHI Bill identified the high cost of private healthcare and the onerous burden of out-of-pocket payments as barriers to access healthcare. However, the Health Market Inquiry Report made significant recommendations to ensure a more competitive private healthcare market, addressing these concerns.

[73] Page 48 of the AG's General Consolidated Report PFMA 2018-19.
[74] Page 48 of the AG's General Consolidated Report PFMA 2018-19.

3.2. **The Urgent Need to Look at Alternatives to Achieve UHC**

3.2.1. In addition to implementing urgent measures to rebuild the public healthcare sector and implementing the recommendations of the Health Market Inquiry Report, we also submit that an apolitical approach should be adopted to construct a plan to achieve UHC in the South African context.

3.2.2. In this regard, one could consider the approach by the Irish Government. In 2011, the Irish Government published their *White Paper on Universal Health Insurance* (Irish White Paper), proposing to replace their two-tiered health funding system with a universal health insurance, with free primary healthcare at point of use. However, the Irish White Paper also lacked detail on the costing of health services and the plan was subsequently abandoned in 2015.

3.2.3. Ireland did not, however, abandon the idea of achieving UHC. In 2016, a parliamentary select committee was established, with representatives from all political parties (the Oireachtas Committee on the Future of Healthcare), which aimed to achieve cross-party consensus on healthcare reform and fulfilling UHC. The Committee worked with international health policy experts and their subsequent Report (the Sláintecare Report), finalised in May 2017, which stipulated a 10-year health reform plan for Ireland, was adopted by the Irish Government.[75]

3.2.4. We submit there is an urgent need in South Africa to achieve cross-party consensus on how best to achieve UHC. It is vital for the public to be informed of alternative models to provide UHC and not to focus the conversation only on NHI. To be opposed to NHI does not mean that one is opposed to the idea of achieving UHC.

3.2.5. We thank you for your kind consideration of our submission and are available to make an oral submission to the Committee if so requested.

[75] See - https://www.oireachtas.ie/en/press-centre/press-releases/20170530-future-of-healthcare-committee-publishes-slaintecare-a-plan-to-radically-transform-irish-healthcare/. In 2019 the Irish Minister of Health published a Sláintecare Action Plan for 2019.