Submission By The Board of Healthcare Funders NPC To The Select Committee On Health and Social Services On The National Health Insurance Bill [B11B-2019], s76

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INTRODUCTION

1. The Board of Healthcare Funders NPC (BHF) is a South African non-profit company and a representative association for most healthcare funders in South Africa.

2. The Board of Healthcare Funders is thankful for this opportunity to comment on the National Health Insurance Bill [B11B-2019] and would be happy to answer any questions or provide further clarification concerning this submission at any time or in any oral hearings concerning the Bill.

3. BHF wholeheartedly supports the concept of Universal Health Coverage (UHC) as defined by the World Health Organisation. UHC means that all people have access to the full range of quality health services they need, when and where they need them, without financial hardship[1].

4. BHF supports the concept of National Health Insurance**. However, it strongly disagrees with the approach of the National Health Insurance Bill that public health care funding must increase at the expense of medical schemes.** The private health funding sector in South Africa should not be sacrificed in favour of NHI. It is too valuable in terms of jobs, scarce skills, infrastructure, financial investment, the quality of its health care services its beneficiaries receive, the value it adds to the economy and the support it has lent to the public health sector.[2] .

[1] https://www.who.int/news-room/fact-sheets/detail/universal-health-coverage-(uhc)
[2] https://www.news24.com/news24/southafrica/news/qa-state-patients-in-private-hospitals-whats-the-deal-20200714; https://www.reuters.com/article/us-health-coronavirus-safrica-hospitals-idUSKBN23E0EQ

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5. BHF does not believe that public health care funding through NHI will cure all of the ills of the health sector. Money alone is no guarantee of increased efficiency and better management in public health facilities, improved availability of human resources for public health care, less waste and corruption, improved access to health care for all, and improved quality of health care services is also required.

6. Weakening any element of the private health sector will weaken the national health system, not strengthen it.

7. While the NHI Bill does acknowledge the role of medical schemes in the future, there is an inescapable sense of hostility towards them in various public statements in the media, amongst certain members of Parliament and others. The lack of detail in the NHI Bill itself in this area provides no reassurance and there is a justifiable belief within the medical schemes industry that the ultimate intention is to render medical schemes unsustainable. **BHF cannot support this position.**

COMMENTARY ON THE BILL

The principles set out below are typically contained in more than just one section of the Bill. Reference will be made by way of example to key sections, or proposed amendments to other legislation in the Schedule to the Bill, that contain the principle raised but BHF's comments must be read as referring to all sections of the Bill that support that particular principle.

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1. Principle: Medical schemes may only offer complementary cover.

1.1 BHF firmly supports the freedom of the people of South Africa to spend their disposable income as they see fit, including insuring any of their health needs through medical schemes.

This right is derived from the constitutional value of personal freedom in a democratic society and the rights to human dignity[3], privacy[4], freedom of association[5], freedom of thought, belief and opinion[6] and the right to have access to health care services and emergency medical treatment[7].

1.2 These constitutional rights are further supported by the right to participate in decisions "affecting their personal health and treatment" as set out in section 8(1) of the National Health Act. These decisions do not relate solely to treatment but to health care financing as well since they affect personal health.

1.3 BHF is opposed to the provisions of **section 6(o) and section 33** of the Bill for 6 reasons-

i. It restricts medical scheme cover to "complementary cover" which in BHF's view is unconstitutional as described above.

3 Section 10 of the Constitution
4 Section 14 of the Constitution
5 Section 18 of the Constitution
6 Section 15 of the Constitution
7 Section 27 of the Constitution

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ii. It allows the Minister of Health complete freedom to decide when NHI is fully implemented which vests too much power in a single official. Parliament has no say in the matter and neither, strictly speaking, does Cabinet since the decision rests solely with the Minister.

iii. It affords no guidance or criteria as a basis on which the Minister must decide which creates significant legal uncertainty for medical schemes and their members and offends against the constitutional requirement of legal certainty which is part of the rule of law;

iv. It creates a risk of arbitrary decision making by the Minister in declaring NHI to be fully implemented, which offends against the constitutional requirement of administrative justice;

v. The term "services" as used in section 33 is not defined in section 1 of the NHI Bill. The term "health care services" is so defined but not used in **section 33.** The term "services" is therefore overbroad and non-specific and could cover a multitude of non-health care services.

vi. **Section 33** states that medical schemes may only fund "services" that are complementary to "services not reimbursable by the Fund". This can be read to mean that medical schemes cannot even comprehensively cover health care services *not* covered by the Fund. They can only fund a certain portion of services not covered by the Fund, presumably after the patient has paid the bulk of the fee out of their own pocket. This is a language error reflecting poor legal draftsmanship and should be rectified (see further below).

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vii. The words "complementary" and "top-up" as used in the definition of "complementary cover" in **section 1** of the Bill are confusing. The Bill does not define what is meant by "top-up" cover. The term "top-up" suggests that medical schemes may indeed offer cover for health care services that are **included** in the NHI benefits, but only over and above the NHI benefit limit.

For example, if the NHI benefit limit for a daily ward fee is R600, and a patient uses a facility that charges a daily ward fee of R800, a medical scheme can pay the extra R200?

1.4 **Section 33** of the NHI Bill is incorrectly drafted. In **section 1** "complementary cover" is defined as "*any third party* payment for personal health care service benefits *not reimbursed* by the Fund, including any top up cover offered by medical schemes registered in terms of the Medical Schemes Act or any other private voluntary insurance fund" (writer's italics). *By the way, does this mean that a father who pays out of his own pocket for his adult daughter to give birth in an unaccredited private hospital is a third party providing "complementary cover"?*

1.5 **Section 33** allows the Minister to "spring" the news on medical schemes with no advance warning that they may only provide complementary cover from now on. **This is not acceptable.** Medical schemes as responsible financial institutions need to be able to plan ahead and prepare for this event by amending their rules, re-designing benefit packages and revising financial and marketing plans in order to comply with the NHI Act and communicate appropriately with their members.

1.6 There are absolutely no indicators in **section 33** as to when the Minister can decide to make a determination that NHI is fully implemented. Section 33 is thus contrary to the constitutional principle of administrative justice and allows the Minister to act arbitrarily.

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The determination by the Minister is an administrative decision which is subject to section 33 of the Constitution and the Promotion of Administrative Justice Act No 3 of 2000. As such, it must be lawful, reasonable and procedurally fair. *How is the Minister to know what will make his decision lawful if Parliament gives him no guidance in the NHI Act?* The Minister is not the lawmaker. That is Parliament's role.

1.7 The Constitutional Court in *Dawood and Another v Minister of Home Affairs and Others* 2003 (3) SA 936 (CC)[8] has said that the Constitution makes it plain that all government officials when exercising their powers are bound by the provisions of the Constitution. There is, however, a difference between a court's discretion to interpret legislation in a manner consistent with the Constitution and conferring a broad discretion upon an official who may be quite untrained in law and constitutional interpretation. The court said that officials are often extremely busy and have to respond quickly and efficiently to many requests or applications. The nature of their work does not permit considered reflection on the scope of constitutional rights or the circumstances in which a limitation of such rights is justifiable. The Minister of Health too is not a legal expert and is a very busy official.

1.8 The Constitutional Court in Dawood held that "**if broad discretionary powers contain no express constraints, those who are affected by the exercise of the broad discretionary powers will not know what is relevant to the exercise of those powers or in what circumstances they are entitled to seek relief from an adverse decision…The legislature must take when legislation is drafted to limit the risk of an unconstitutional exercise of the discretionary powers it confers"**

8 https://collections.concourt.org.za/handle/20.500.12144/2084

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1.9 **Section 33 of the Constitution** states that everyone has the right to administrative action that is lawful, reasonable and procedurally fair. This includes medical schemes and their members.

1.10 **Section 195 of the Constitution** which deals with public administration, provides that public administration must be governed by the democratic values and principles enshrined in the Constitution, including the following principles –

- Peoples' needs must be responded to, and the public must be encouraged to participate in policy-making;
- Public administration must be accountable;
- Transparency must be fostered by providing the public with timely, accessible and accurate information.

According to section 195 (2) of the Constitution, these principles apply to –

(a) administration in every sphere of government;

(b) organs of state; and

(c) public enterprises[9].

1.11 To the extent that the NHI Bill interferes with people's freedom to spend their disposable income as they see fit, the relevant provisions of the NHI Bill are unconstitutional. This is most starkly demonstrated in the proposed amendments to the Medical Schemes Act No 131 of 1998 in the Schedule to the Bill in terms of which medical schemes will not be permitted to fund "the giving of advice in relation to, or treatment of, any condition arising out of a pregnancy, including the termination thereof". If people wish to contribute towards a medical scheme to have their baby in a private health establishment of their

[9] See also the dicta of the Constitutional Court in *Minister of Health and Another v New Clicks South Africa (Pty) Ltd and Others (*CCT 59/2004) [2005] ZACC 14

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choice what is the constitutional justification for not allowing this as long as they are paying the taxes that fund NHI?

1.12 Also, to the extent that the NHI Act will have the effect of reducing medical scheme beneficiaries' access to particular health care services, medicines and health technologies, it is unconstitutional. Medical scheme members are not subject to rationing protocols applicable in the public health sector, e.g. eligibility for renal dialysis[10]. If medical scheme beneficiaries are bound by state determined formularies and clinical and rationing protocols and in the process, effectively deprived of access to health care services, medicines and health technologies that they currently enjoy, this will be unconstitutional.

1.13 The state is obliged by section 7 of the Constitution to respect, protect, promote and fulfil the rights in the Bill of Rights. A diminution or reduction of the content of these rights by the state is unconstitutional whether it is expressly provided for in legislation or is the intended or unintended consequence of legislation.

1.14 The sections in the NHI Bill that refer to "complementary cover" or that use the word "complementary" in relation to medical schemes are section 1 (the definition section) section 6(o), section 33 and the proposed amendments to the Medical Schemes Act in the Schedule of the Bill. BHF believes that constitutionally speaking, the only solution is to amend the Bill so that medical schemes are not restricted to complementary cover only.

[10] See for instance the constitutional court case of *Soobramoney v Minister of Health (Kwazulu-Natal)* (CCT32/97) [1997] ZACC 17

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1.15 BHF therefore recommends that the Schedule to the Bill is amended so as to remove the proposed amendments to the Medical Schemes Act entirely.

1.16 Even if the abovementioned sections are not removed from the Bill, the proposed amendments to the Medical Schemes Act in the **Schedule** of the Bill are inconsistent with **section 33** of the Bill which permits the Minister to determine, *through regulations* when National Health Insurance has been fully implemented and "medical schemes may only offer complementary cover to services not reimbursable by the Fund".

1.17 The proposed amendments to the Medical Schemes Act suggest that medical schemes will not be bound by the provisions of the NHI Act which is legally impossible. Medical schemes are currently bound by all applicable laws and there is no reason why they would not be equally bound by provisions of the NHI Act. In any event, **section 57 of the Medical Schemes Act** expressly imposes a duty on boards of trustees of medical schemes to "ensure that the rules, operation and administration of the medical scheme comply with the provisions of this Act and all other applicable laws."

1.18 If it is decided that section 33 cannot be removed entirely from the Bill as BHF urges, then **BHF recommends that it should be amended to read as follows** –

"(1) The Minister of Health, in consultation with the Minister of Finance and the Board, must determine a date by Notice in the *Gazette* on which National Health Insurance is fully implemented: provided that all of the following criteria have been met before such Notice is published –

(a) every section of this Act has been brought into operation by a Presidential Proclamation;

(b) a minimum of 75 percent of the population as contemplated in section 4(1) are registered as users in terms of section 5;

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(c) the financial status of the Fund, as determined by the Minister of Finance, is such that it can sustainably reimburse the costs of health care services, health goods, health products, health related products, and medicines as identified by the Benefits Advisory Committee in terms of section 25(5) for a period of at least five years;

(d) at least five District Health Management Offices have been established in each province as contemplated in section 36;

(e) the Health Products Procurement Unit has been established and has been operational within the Fund as contemplated in section 38(1) for a period of at least two years;

(f) a minimum of 80% of public health establishments have been certified by the Office of Health Standards Compliance, accredited by the Fund in terms of section 39(2) and contracted by the Fund in terms of section 39(3);

(g) a minimum of five thousand private health care service providers have been accredited and contracted by the Fund;

(h) the Fund has established appropriate, fully operational and prompt provider payment mechanisms contemplated in section 41 for all health care service providers and health establishments with whom the Fund has contracted, whether they are public or private providers.

(2) From the first date on which any provision of this Act is brought into effect by the President by proclamation in the Gazette as contemplated in section 59, the Minister of Health must every six months publish for public comment a report in the *Gazette*, detailing facts and figures that indicate the level of progress towards achieving the criteria contemplated in subsection (1), including the date, if any, on which the Minister reasonably anticipates that such criteria will be fully met, to -

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(a) inform the general public and give them the opportunity to raise questions and provide comments on the state's progress towards full implementation of National Health Insurance; and

(b) enable relevant and appropriate planning by medical schemes and their members

(3) From the date stated by the Minister in the Notice contemplated in subsection (1), which shall not be less than one year from the date of the Gazette in which such Notice is published, medical schemes may only offer complementary cover."

1.19 If **section 33** of the NHI Bill is amended as recommended above and the amendments to the Medical Schemes Act are completely removed from the Schedule, this will be much fairer to medical schemes and their members and give them time to make suitable arrangements to comply with the NHI Act.

1.20 BHF notes that **section 6(o)** uses the words "complementary voluntary medical insurance scheme" which is not appropriate or consistent with the definition of "medical scheme" in section 1 of the Bill. There is no entity like "a complementary voluntary medical insurance scheme" in South Africa. The section should be amended to read -

"to purchase health care services that are not covered by the Fund through a medical scheme registered in terms in terms of the Medical Schemes Act or out of pocket payments as the case may be."

1.21 BHF points out that in **section 6(o)** the words "private insurance covering an international traveler with a short-term, work or student visa" could be read such that NHI *will* provide health care cover for international travelers and that they only need to purchase private insurance that covers health care services *not covered* by the Fund.

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Whether this is the intended interpretation is hard to say because the Bill is poorly drafted. However, it is possible that the real intention was for international travelers to purchase their own *comprehensive t*ravel insurance to ensure that they are not a burden on the NHI Fund.

2. Principle: Excessive Powers of the Minister in relation to the NHI Fund.

2.1 Ministers and Presidents come and go. Some execute their duties admirably but some put other interests above those of the people. The State Capture Inquiry Report of the Zondo Commission speaks for itself.

2.2 The NHI must remain viable and sustainable indefinitely and must therefore be immune to political interference. Destructive political interference in government agencies is a matter of public record.

2.3 Consider for instance the actions of Minister Bathabile Dlamini regarding the South African Social Security Agency as documented in the constitutional court decisions of *South African Social Security Agency and Another v Minister of Social Development and Others* (CCT48/17) [2018] ZACC 26, *Black Sash Trust v Minister of Social Development and Others (Freedom Under Law NPC Intervening)* (CCT48/17) [2017] ZACC 20 and a March 2022 magistrates court decision finding her guilty of perjury in the 2017 inquiry into the social grants debacle at SASSA that saw millions of grant beneficiaries unsure if they would receive their money[11].

[11] https://www.news24.com/news24/southafrica/news/just-in-bathabile-dlamini-found-guilty-of-perjury-court-rules-20220309 and also https://ewn.co.za/2022/04/01/bathabile-dlamini-handed-4-year-jail-term-or-r200-000-fine-for-perjury

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2.4 Even if the NHI does not provide extra funds for health care but simply uses the equitable share of the provinces to restructure how public health care is funded, BHF is concerned that the necessary health system improvements are not guaranteed. The experience of South Africa with State Owned Enterprises (SOEs) to date has been dismal.

2.5 The inability of the State to successfully manage and operate SOEs features with monotonous regularity in the courts, various Commissions of Inquiry and the media. Consider for example the failures in Eskom, South African Airways, the SABC, Denel, Transnet, the Road Accident Fund, PRASA, SASSA, the SA Post Office, the South African Nuclear Energy Corporation and SARS. Even the President has acknowledged that SOEs and local government are the State's greatest weakness[12]. Why should anyone believe that the NHI Fund will meet a different fate?

2.6 For these reasons **BHF strongly recommends that the excessive powers of the Minister of Health** in the NHI Bill are curtailed by being subjected to restrictions such as the existence of objectively ascertainable criteria for his decisions, or that decisions are made in consultation and or concurrence with other relevant entities such as the Minister of Finance, the Board of the Fund etc.

2.7 The sections of the Bill that grant too much power to the Minister of Health are discussed further below.

Section1: the definition of "this Act" when read with section 3(3) of the NHI Bill allows the Minister and the Fund through directives, rules and notices to *override* all Acts of Parliament except the Public Finance Management Act and the Constitution.

[12] https://www.parliament.gov.za/news/state-owned-enterprises-are-holding-us-back

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This is clearly unconstitutional and totally unacceptable as it gives the Minister the power to erode Parliament's powers to legislate.

BHF recommends that the definition of "this Act" is amended to read as follows –

"this Act" does *not* include any regulation promulgated, directive or rule made, or notice issued by the Minister or directive issued by the Fund in terms of this Act".

2.8 **Section 3(3)** of the Bill does not take into account the provisions of sections 146 and 147 of the Constitution for resolving conflicts between national and provincial legislation. In fact it attempts to override sections 146 and 147. It is therefore unconstitutional. This should be especially concerning to provincial governments because of Schedule 4 of the Constitution and the designation of health services as a functional area of concurrent national and legislative competence.

2.9 There is important constitutionally mandated legislation, in addition to the Public Finance Management Act, that the National Health Insurance Act cannot be permitted to override such as the -

i. Promotion of Administrative Justice Act (s33 of the Constitution),
ii. Citizenship Act (s3(3) of the Constitution)
iii. Promotion of Equality and Prevention of Unfair Discrimination Act (s9(4) of the Constitution)
iv. annual Division of Revenue Act (s214 of the Constitution),
v. Promotion of Access to Information Act (section 32(2) of the Constitution)
vi. Public Service Act, (s195 of the Constitution)
vii. Public Procurement legislation contemplated in section 217(3) such as the Preferential Procurement Policy Framework Act no 5 of 2000 or the Public

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Procurement Bill [B18-2023] which was recently tabled in Parliament by the Minister of Finance; and

viii. Protection of Personal Information Act No 4 of 2013 which is based on the constitutional right to privacy and Data Protection principles recognized in international law.

2.10 **BHF therefore recommends that section 3(3) of the NHI Bill is entirely deleted.** While it may be fashionable for legal drafters to include such provisions in legislation, it is not constitutionally advisable given the plethora of legislation that is mandated by the Constitution, the restrictions on and special status of Money Laws, the allocation of certain functions regarding financial legislation to the Minister of Finance alone and the fact that the Minister of Health is responsible only for a single limited portfolio in Cabinet. What about the portfolios of the other Cabinet Ministers?

2.11 Sections 4(1) and 7(1) of the Bill allow the Minister to veto purchasing decisions by the Fund. This allocates excessive powers to the Minister of Health. **If the Board is to be held fully accountable for the corporate governance of the Fund, the phrase "in consultation with the Minister" in these sections should read "after consultation with the Minister".** The Minister of Health is just one person. As such s/he represents an administrative bottleneck to the effective functioning of the Fund, a material risk of political interference in key decisions of the Board and a profound risk of corruption in the procurement functions of the Fund. The NHI Bill cannot leave the successful implementation of NHI up to just one person who is not even guaranteed to be an expert in healthcare financing.

2.12 It does not help that the Board of the Fund is also bound by the decisions of the Benefits Advisory Committee (BAC) in the purchasing of health care services.

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The BAC does not contain a majority of health care financing experts and makes provision only for expertise in health economics on the financial side (section 25(2)). This is insufficient. There should be medical and financial experts on the BAC in equal numbers.

2.13 The expertise of actuaries, experts in financial management such as chartered accountants, pharmaco-economist, public finance and statistical analysts is currently under-represented on the BAC**. BHF recommends that if the Fund is to be bound by the decisions of the BAC**, **provision is made for the appointment of actuaries, chartered accountants with experience in health care funding, and public health finance experts to the BAC.** Furthermore **BHF recommends that the Bill specifies an upper limit to the number of persons that the Minister can appoint to the BAC.** If the BAC it too large it will become ineffective and unwieldy and may not be able to agree on anything.

The above would be an acceptable compromise but is not ideal. The BAC has no vested interest in the success of the Fund and it undermines the accountability of the Board of the Fund because it essentially makes benefit decisions by which the Board is bound. In **section 4(1)** of the Bill the wording is that the Fund must purchase health care services "determined" by the Benefits Advisory Committee. **See section 7(1)** which also uses the word "determined" in this context. As such the BAC is not an *advisory c*ommittee at all. It has the power to make decisions which are binding on the Fund. **BHF strongly recommends that the decisions of the BAC are not binding on the NHI Fund as far as NHI benefits are concerned.**

2.14 As a purely *advisory* committee, the BAC should make recommendations that the Board must take into consideration but the Board must bear ultimate responsibility for deciding on the health benefits purchase by the Fund.

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This decision has to be based on financial, actuarial and legal factors, not just epidemiological and public health factors. Otherwise accountability becomes diluted to the point where no-one can truly be held accountable. If the Board cannot take key financial and legal decisions involving benefit design, i.e. NHI benefits, who it contracts with and how it contracts, and how it conducts the business of the Fund, the Board is merely a puppet that cannot exercise proper corporate governance over the Fund. The Board has insufficient financial, legal and other control over the Fund such that it is really the Minister of Health, the Benefits Advisory Committee and similar entities that must be held accountable for the financial performance of the Fund.

2.15 **Section10(1)(m) of the Bill** states that the Fund must account to the Minister on the performance of its functions and the exercise of its powers. **Section 12 and 15(1) of the Bill** echo this sentiment stating that a "Board that is accountable to the Minister is hereby established to govern the Fund…" and the Board is "accountable to the Minister" respectively.

2.16 However, since the Minister effectively has control over many of the Fund's key functions and powers, e.g. the purchasing of health care services, the Fund alone cannot be held completely accountable without acknowledging the Minister's responsibility for decisions he or she has taken "in consultation with" the Board of the Fund. **Since no-one should be a judge in his own case, the Minister is not independent enough in matters affecting the Fund for the Fund to be properly accountable to him or her.** For example, if the Fund does not do something and the Minister asks the Fund why it did not do this, the Fund can turn around as say to the Minister "because you vetoed our decision". Who then is accountable? The Minister or the Fund?

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2.17 If the Minister is intimately involved in the manner in which the Fund performs its functions and exercises its powers, as the Bill provides, then it is not to the Minister that the Fund should be accountable because the Minister cannot be accountable to himself. The Minister is accountable to the President for the execution of his or her duties.

2.18 See another example in **section 11(1)(i)(vii) of the Bill** which provides that the Fund must identify, develop, promote and facilitate the implementation of best practices in respect of the design of the healthcare service benefits to be purchased by the Fund, "in consultation with the Minister". This once again gives the Minister the power to veto the decisions of the Fund in this area. In this sense, accountability of the Fund within the system as a whole is unacceptably diminished.

2.19 See too the example in **section 11(1)(i)(viii)** of the Bill which says the Fund must identify, develop, promote and facilitate the implementation of best practices in respect of referral networks in respect of users, "in consultation with" the Minister. The Minister can thus effectively hobble the Fund in performing these functions. No one wants to see the SASSA fiasco with repeated.

2.20 **Section 10(3)** of the Bill only makes the situation worse because it seeks to entrench in law, "health policies approved by the Minister". This is constitutionally unacceptable for a number of reasons. The Minister does not have the power to determine national health policy on his/her own. It is the role of the President in Cabinet to exercise the executive authority of the Republic by "developing and implementing national policy" (**section 85(2)(b) of the Constitution**.)

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2.21 The Minister of Health is just one member of Cabinet and is certainly not the President. Also policy, by definition, is not law and cannot have the status of law due to the manner in which it is created. The Constitution contains express mechanisms for the creation of law and it is a function of Parliament, not the Minister of Health, to make law.

2.22 The Board of the Fund cannot even determine its own internal procedures such as rules for the attendance of Board meetings, voting by Board members, a code of conduct for Board members, and the manner in which meetings are minuted etc. without the Minister's agreement ("in consultation with the Minister) in terms of **section 17(3) of the Bill.** The Minister must not be allowed to interfere with the functioning and processes of the Board.

2.23 Section 31(1)(b) is also highly problematic because it gives the Minister responsibility "for governance and stewardship of the Fund in terms of the provisions of this Act". **The Board of the Fund must be responsible for the corporate governance of the Fund otherwise why bother with a Board at all?** The Board of the NHI cannot be an empty puppet behind which the Minister of Health hides. It is bordering on deceitful to create a Board without full executive powers over the public entity for which it is to be held responsible. **No single person, even the Minister of Health, can have all the knowledge and expertise necessary to make the appropriate decisions for a massive public enterprise such as the National Health Insurance Fund.**

2.24 What is more the Minister of Health will be stretched too thin between his/her duties as Minister of Health regarding health service delivery and the governance of the Fund. The National Health Act defines the "national health system" as "the system within the Republic, whether within the public or private sector, in which the individual components are concerned with the financing, provision or delivery of health services." Rather than being distinct from the national health system therefore, the Fund is part of it.

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2.25 **BHF therefore recommends the deletion of section 31(1) of the NHI Bill.** The Minister's powers cannot be greater than those conferred on him/her by the Constitution as a member of the national executive appointed by the President. *The Minister is not solely responsible for the stewardship and governance of the national health system.* That is the role of the President in a Cabinet that includes the Minister.

2.26 These days, there is an unfortunate tendency to confuse the term "governance" with "government". The Minister is a member of Cabinet, in which, together with the President, the executive authority of *government* resides. The Minister is also a Member of Parliament in which the legislative authority of *government* resides. By contrast "governance" is used to indicate corporate governance in the sense of the establishment of rules and procedures for the proper, appropriate and sustainable operation of a business or state-owned enterprise - see for example the internationally recognized King IV Code on Corporate Governance developed in South Africa.

2.27 **BHF therefore recommends that the Fund should account to the President in Cabinet (the national executive) or Parliament on the performance of its functions in the exercise of its powers.**

3. Principle: Accreditation and Contracting And Barriers To Access

3.1 The NHI Bill sets up a three-barrier system for a health service provider, health establishment or supplier to be recognized under NHI. A health service provider (either public or private sector provider) must be -

- registered with the relevant statutory professional council;
- accredited by the Fund; and
- contracted by the Fund

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A health establishment must be -

- certified by the Office of Health Standards Compliance;
- accredited by the Fund; and
- contracted by the Fund

3.2 The requirements for accreditation of suppliers as defined in section 1 are totally missing from the Bill and it is unacceptable that criteria for accreditation of health establishments and health care service provider are stated in the Bill whilst those for suppliers are not. There is already extensive Treasury legislation (PFMA) and rules for how suppliers to government generally are 'accredited'. The Bill should state what *additional* criteria are necessary under NHI so that suppliers have legally certainty. This cannot be left to regulations made by the Minister. **Section 10(1)(b)** of the Bill states that the Fund must actively purchase and procure healthcare services, medicines, health goods and health related products from health care service providers, health establishments and suppliers that are certified and accredited "*in accordance with the provisions of this Act".*

3.3 **Who will certify such suppliers if they do not operate health establishments as defined in the Bill?** The OHSC only has the power to certify health establishments. Suppliers of prostheses, hospital beds, drip bags and drip stand, sutures, medical dressings etc. do not operate as health establishments.

3.4 **The NHI Bill does not consider the Certificate of Need provided for under the National Health Act** which is currently the subject of litigation. If the Minister of Health succeeds in preserving the Certificate of Need provisions of the National Health Act, this will create a fourth barrier for health service providers and health establishments to

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overcome before they can be accredited. Remember that the definition of a health establishment is extremely wide and affects all health service providers.

3.5 **What happens if health establishments and health service providers are accredited by the Fund but not contracted by the Fund?** There is no guarantee of being contracted after accreditation. Will the Fund still pay for services they render to users? The Bill is silent on the matter. Section 10(1)(j) says that the Fund must develop and maintain a service and performance profile of all accredited **and contracted** health care service providers, health establishments and suppliers. **Section 35(2)** says the Fund must reimburse payment directly to accredited **and contracted** central, provincial, regional, specialize in district hospitals… **Section 35(3)** three says funds for primary healthcare services must be reimbursed directly to accredited and contracted primary health care service providers and health establishments…. See also **section 35(4)(a) and (b), section 38(6) and section 55(b)** of the Bill in this regard. Why would a provider go to the trouble and expense of being accredited if there is no NHI Fund contract at the end of the process?

3.6 The provisions of the Constitution on public procurement, the Public Finance Management Act (PFMA) and other relevant procurement laws applicable to organs of state make contracting a drawn-out process with specific steps that must be followed. Furthermore, contracts require the consent of both parties. **The Fund cannot just confer a contract on anyone it pleases.** Contracts must be negotiated through various processes. The National Treasury Regulations made under the PFMA are applicable to government departments, public entities, and constitutional institutions. The Minister of Health has no authority to override them or amend them under the NHI Bill and s/he should not be given such authority by the Bill either.

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3.7 **The accreditation and contracting process as envisaged in the Bill are likely to take considerable time.** In the meantime, if certain sections of the NHI Act are brought into operation prematurely, the implications for access to healthcare services for users could be disastrous. Constitutionally speaking, they cannot be refused emergency medical services or denied access to healthcare services. What happens if the NHI Act is brought into effect when insufficient numbers of health establishments and health service providers have been accredited and contracted? The Bill does not make provision for this. That is why the amendment proposed by BHF in **paragraph 1.19** of this submission is essential. The transitional provisions of the Bill in section 57 are weak and severely lacking in detail.

3.8 In the Bill "accredited" is defined in **section 1** as meaning "to be in possession of a valid certificate of accreditation from the Fund as issued in terms of section 39". Accreditation applies to all health establishments, both public and private

3.9 Section 39 sets out the criteria for accreditation. **Note that the definition of a "health establishment" is very wide.** The NHI Bill imports it from section 1 of the National Health Act. The definition reads as follows –

"health establishment" means the whole or part of a public or private institution, facility, building or place, weather for profit or not, that is operated or designed to provide inpatient or outpatient treatment, diagnostic or therapeutic interventions, nursing, rehabilitative, palliative, convalescent, preventative or other health services."

3.10 Since every health professional works in a health establishment every single health establishment will have to be accredited by the Fund before it can be contracted and paid by the Fund. **It will not be sufficient that the health service provider who works in that establishment is accredited.**

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For example, a private general practitioner who works in private rooms will have to get those rooms accredited in terms of section 39 of the NHI Bill even if s/he is herself accredited by the Fund as a health service provider because s/he is registered with the Health Professions Council and meets the other requirements of section 39. It is similar to the way in which private pharmacies are regulated at present. Not only must the pharmacist have all the necessary professional qualifications and be registered with the Pharmacy Council, the premises of the pharmacy must also be inspected, approved and licensed.

3.11 **Section 39(2)(b)** of the Bill says that in order to be accredited, a health care service provider or health establishment must be in possession of and produce proof of certification by the Office of Health Standards Compliance. **The majority of public sector hospitals in South Africa do not currently have such certification.** Although many have been inspected by the OHSC, they have not met the necessary standards. It must be noted that it is a requirement of s79(1)(b) of the National Health Act for the Office to inspect and certify health establishments as compliant or non-compliant with prescribed norms and standards all, where appropriate and necessary, withdraw such certification.

3.12 What will government do if the majority of public hospitals and clinics cannot be accredited by the Fund because they have not been certified? It is legally unacceptable and constitutionally impermissible to provide health care services that threaten the health and lives of patients but it is also not constitutionally permissible to deny access to health care services.

If private sector hospitals and clinics are certified and most public sector hospitals and clinics are not, the Fund will be forced to contract heavily with the private sector.

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It is not sufficient that the Minister may make regulations in terms of **section 55(1)(h)** of the Bill on "the accreditation and conditional accreditation of health service providers, health establishments or suppliers".

3.13 The Minister of Health can only make regulations within the scope of the provisions of the National Health Insurance Act. He will not lawfully be able to make regulations that bypass or otherwise undermine the principles and requirements of the Act itself. If certification by the OHSC is a requirement of accreditation in terms of the Act, the Minister will not be able to make regulations to the contrary.

3.14 **Section 39 of the Bill** creates very onerous conditions for accreditation and seeks to apply a poorly conceived, one-size-fits all approach to very diverse range of health service providers and health establishments.

3.15 Why must a private GP or dentist provide a "budget impact analysis" as stipulated in section 39(2)(c)? **BHF recommends removing the requirement of a budget impact analysis from section 39(2)(c).** It is not appropriate for every kind of health service provider or health establishment; it may apply to service providers who intend to introduce new healthcare technology.

3.16 Health professionals are legally limited by their scope of practice. A psychologist may not practice as a GP, a surgeon may not practice as a psychologist, a physiotherapist cannot offer speech therapy, a chiropractor may not perform orthopaedic surgery etc.

3.17 **Section 39(2)(c)(ii)** of the NHI Bill says in order to be accredited a health care provider must "meet the needs of users and ensure compliance with prescribed performance criteria… including the allocation of the appropriate number and mix of healthcare professionals, in accordance with guidelines, to deliver the healthcare services

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specified by the Minister…". Again too much power is given to the Minister here. The Minister cannot act however he chooses or make laws or administrative decisions any way he pleases. That is not consistent with how a constitutional democracy works.

3.18 How will the Minister "specify" these guidelines? Will they simply be published in the Gazette? If they are only "guidelines" then why are they being entrenched in law? Guidelines are just that – they guide people they do not bind people. They are not laws or regulations. The Minister cannot legislate.

3.19 Furthermore, there is no suggestion that **section 39(2)(c)(ii)** applies only to health establishments. It applies to medical practices as well. Private health professionals must be free to operate as sole practitioners if they wish. They cannot force other health professionals to join them. This provision in the Bill is in violation of section 22 of the Constitution which grants a right to freedom of trade, occupation and profession. If this provision has the effect of denying access to health care services by stifling private health professionals, then it is unconstitutional.

3.20 The Bill makes no reference to fees that may be charged for accreditation. The National Health Act does allow for fees payable to the Office of Health Standards Compliance for certification. The costs to health establishments, health service providers and suppliers must not be too onerous otherwise this will create an imbalance in the system as providers don't seek accreditation. BHF recommends that NO fee is charged by the NHI Fund for accreditation, otherwise providers, both public and private will have to try and recover this cost in their fees and will push for higher fees.

The NHI Fund must always be mindful of the pressure it exerts on the costs of doing business with health care service providers etc. If the costs of doing business with the Fund are too great, they may decide not to contract with the Fund at all.

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3.21 So much is dependent on the accreditation system in the NHI Bill that if it is not properly implemented, is not swift, reasonable, fair and efficient, NHI will fail. Parliament cannot afford to make mistakes in the legislation with the accreditation system. See for example -

3.20.1 **Section 1**: "strategic purchasing;" means the active purchasing of health care services by the pooling of funds and the purchasing of comprehensive health care services from *accredited and contracted providers.* If providers are not accredited and contracted, then it is not "strategic purchasing".

3.20.2 **Section 2(c):** strategic purchasing of health care services, medicines, health goods and health related products from *accredited and contracted* providers. The use of the word "providers" here is wrong. **It should read** "from health care service providers, health establishments and suppliers" because these are the terms used in the rest of the Bill.

3.20.3 **Section 4(4):** a person seeking health care services from *an accredited* health care service provider must be registered as a user. **Therefore only users can only seek health care services from an accredited provider.** If a person is *not* a user does this mean he or she cannot seek health care services from an accredited provider? If so, this section is a violation of the constitutional right of everyone to have access to health care services. It is also a violation of the section 22 constitutional right to freedom of trade, occupation and profession for private sector providers and health establishments.

3.20.4 Note that the provider does not have to be contracted - only accredited.

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So even the provider is not being paid by the Fund for services to users (no contract with the Fund) but s/he cannot service non-users either ? How can that possibly be constitutional? **BHF thus recommends that section 4(4) of the Bill is amended to read as follows –**

"a person seeking health care services purchased for his or her benefit by the Fund from an accredited and contracted health care service provider or health establishment must be registered as a user in terms of section 5 if he or she is eligible in accordance with section 4".

3.20.5 Section 5(8) contains a similar provision to section 4(4) and is objectionable and unconstitutional on the same grounds. "A person seeking healthcare services purchased for his or her benefit by the Fund from an accredited health care service provider or health establishments *must be registered as a user*…." **This also violates sections 27(1), 27(3) and 22 of the Constitution.** A person who is not eligible in terms of section 4 of the Bill *cannot* register as a user. The implication is that persons who are not users are not allowed to seek healthcare services from any provider accredited by the Fund which is constitutionally unacceptable. **BHF recommends that section 5(8) is amended to read as follows –**

""a person seeking NHI funded health care services purchased for his or her benefit by the Fund from an accredited and contracted health care service provider or health establishment must be registered as a user in terms of section 5 if he or she is eligible in accordance with section 4".

3.20.6 Section 5(1), 5(2) and 5(4)(b): a person must register as a user *at an accredited* health care service provider or health establishment. Why not "accredited and contracted"? **Only contracted health service providers** will

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be paid by the NHI Fund. This is problematic because the NHI Bill restricts users to receiving health care services from the health care service provider or health establishment with whom they have registered in section 7(2)(a). If that provider or health establishment is accredited but not contracted the user will not be able to access NHI benefits from them. **BHF therefore recommends that these sections must be amended in each case where the word "accredited" occurs to "accredited and contracted"**

3.20.7 **Section 7(2)(b)** does not remedy the defect in section 5(1), 5(2) and 5(4)(b) read with section 7(2)(a). It says that should the user be *unable to access the healthcare service provider or health establishment* with whom or at which the user is registered in terms of section 5, such portability of health services *as may be prescribed* must be available to that user. However the user in this example **can** access the *healthcare service provider or health establishment* with whom s/he has registered. This user cannot, however, access the NHI benefits to which he or she is entitled because the healthcare service provider or health establishment is not **contracted t**o the NHI Fund. i.e. the user cannot receive health care services free at the point of care because there is no **contract** between the provider and the Fund.

3.20.8 **Section 10 (1)(d)** requires the Fund to enter into **contracts** with accredited providers. So does **section 7(2)(e), section 11(2), section 32(2)(a),section 35(2),(3) and (4), section 37(2)(c**). Section 2(c) of the Bill refers to "strategic purchasing" of health care goods etc. from "accredited **and contracted**" health care service providers. It is clear from this that mere accreditation is not enough. The provider must be accredited and contracted, and every relevant section of the Bill must reflect this.

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3.20.9 See for example **Section 6(a)** of the Bill which says users are entitled to receive necessary quality healthcare services free at the point of care from an *accredited* healthcare service provider or health establishment. So health care service providers and health establishments don't need to be contracted as well as accredited? **The Bill creates unconstitutional uncertainty regarding accreditation and contracting.**

3.20.10 **Section 7(2)(e) says** the Fund **must** enter into contracts with *accredited* health service providers and health establishments at primary health care and hospital level based on the needs of users and in accordance with referral pathways.

3.20.11 **Section 7(3):** "portability of health care services" means the ability of a user to access healthcare services by an *accredited* healthcare service provider or at an *accredited* health establishment other than by the healthcare services provider or the health establishment with whom that user is registered. It should be "accredited and contracted".

3.20.12 Currently, any person can access health care services anywhere in South Africa. **They will not be able to under the NHI Act.** It is once again left to the Minister to decide, by making regulations, the basis on which a user will be able to access health care services from any health care service provider or health establishment other than the one at which he or she is registered. The Minister should not be allowed through regulations to limit the constitutional right of access to health care services.

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There must be provisions in the Bill itself that limit the Minister's powers regarding restrictions on access such that the Minister is guided by Parliament through the NHI Act as to how these portability regulations must be made. **BHF recommends that section 7(3) of the Bill is at least amended to read –**

"For the purpose of subsection 2(b), "portability of health care services", in respect of a user, means the user must be able to access health care services from an accredited and contracted health care service provider or health establishment, other than the health care service provider or health establishment at which that user is registered in terms of section 5, wherever the user happens to be in South Africa at the time when such health care services are needed."

3.20.11 **Section 8(1):** a user is only entitled to receive health care services from an *accredited* health service provider or health establishment free at the point of care. *However, if there is no contract with the Fund, the health service provider or health establishment will not get paid.* **BHF recommends that section 8(1) of the Bill is amended to read –**

"A user of the Fund is entitled to receive the health care services purchased on his or her behalf by the Fund free at the point of care from an accredited and contracted health care service provider or health establishment"

3.20.13 **Section 10(1)(b):** Health service providers, health establishments and suppliers must be *certified and accredited* in accordance with the provisions of this Act, the National Health Act and the Public Finance Management Act.

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The National Health Act only makes provision for certification by the OHSC, **not** accreditation. There is potential for misinterpretation of section 10(1)(b). **BHF recommends that section 10(1)(b) is amended to read -**

> "pool the allocated resources in order to actively purchase and procure healthcare services, medicines, all good and health related products from health care service providers, health establishments and suppliers that are certified, where applicable, by Office of Health Standards Compliance in accordance with the National Health Act, registered in terms of the Public Finance Management Act and accredited in accordance with the provisions of this Act."

3.20.14 The Public Finance Management Act and the National Treasury require the registration of prospective service suppliers to organs of state on the Central Supplier Database (CSD)[13]. Section 10(1)(b) therefore introduces a fifth barrier to private health care service providers, health establishments and suppliers in providing NHI funded health care services, health goods etc.

Key information of prospective suppliers is verified on the CSD in line with PFMA and regulatory requirements and registration on the CSD is a prerequisite for the awarding of any bids for price quotations.

3.20.14 This potentially gives public health care providers and health establishments an unfair advantage over their private counterparts in the NHI system - especially given the fact that many such public entities are worse off than most private entities in terms of efficiency, wastefulness, corruption,

[13] National Treasury Instruction No 4A of 2016/2017 Central Supplier Database. http://ocpo.treasury.gov.za/Resource_Centre/Legislation/Instruction%20no%204A%20of%201617%20Central%20Supplier%20Database.pdf

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maladministration and mismanagement. If the NHI Fund does not contract with private providers of health care services the public sector will be unable to handle the extra burden of medical scheme beneficiaries and this could result in an unconstitutional reduction in access to health care services for said beneficiaries. Moreover many public sector patients are no doubt looking forward to being able to access health care services from GPs and other health professionals in private practice given the large numbers that already do so if they have the ready cash.

3.20.15 **Section 10(1)(d):** the Fund **must** enter into contracts with *accredited* health care service providers based on the health care needs of users.

3.20.16 **Section 10(1)(j):** the Fund must develop and maintain a service and performance profile of all *accredited and contracted* healthcare service providers, health establishments and suppliers; Note: those that are only accredited but not contracted are irrelevant.

3.21 **Section 20(5)(c):** the CEO of the Fund must submit to the Board an annual report of the activities of the Fund which must include the number of *accredited and approved* health care providers. Why "approved" and not "contracted". **This must be amended from "approved" to "contracted".** It looks like a drafting error but such errors matter in law more than in any other text since they impact how the law is interpreted.

3.22 What if a person has no choice but to obtain healthcare services from a **non-accredited** healthcare service provider in the public or private sector because insufficient numbers of health care service providers have been accredited and contracted? Will they be denied by the Fund? The Bill is silent on this important issue except to say in **section**

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7(2)(b) that the Minister may make regulations on the portability of health services which does not address this problem.

4 Principle: The Bill Creates Unconstitutional Barriers to Access

4.20 Many of the Bill's provisions create some intended and unintended additional barriers to access to health care services that do not currently exist. **This is fundamentally unconstitutional**. These barriers are not only reflected in the accreditation and contracting system for providers.

4.21 Barriers are also reflected in the Minister's powers in terms of **section 7(2)(b)** to make regulations on portability of health services – implying further rules with which a user will have to comply. At present any South African or resident can approach **any** health establishment or health service provider he chooses to obtain health care services. **How is restricting this constitutionally justifiable? Why should solely the Minister of Health have the power to do so by regulations?** Residents of South Africa travel within South Africa a great deal for work, business, holidays, religious gatherings, social and family gatherings, study purposes etc.

Why should they only be allowed to access the health care service provider or health establishment with which they have registered as stated in **section 7(2)(a)** of the Bill? BHF recognises that there is a need for appropriate referral pathways when the need arises. However there may be circumstances when this pathway may lead to delayed healthcare provision and some negative consequences or health outcomes as a result of the delays.

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4.22 The arduous registration requirements imposed on users by **section 5(3)** of the Bill also create unconstitutional barriers to access to health care services. Why is an original birth certificate necessary if a person has a national identification document? **Is it the intention to discriminate on the basis of country of origin?** BHF recommends that the word "or" is inserted at the end of paragraph 5(3)(a), before 5(3)(b) of the Bill.

4.23 **Section 9(2) of** the Constitution stipulates that the state may not unfairly discriminate directly or indirectly against anyone on one or more grounds, including race, gender, sex, pregnancy, marital status, ethnic or social origin, colour, sexual orientation, age, disability, religion, conscience, belief, culture, language **and birth**. If a user was born in a foreign country but is now a South African citizen or permanent resident they will be prejudiced by this provision because obtaining an original birth certificate from another country is not easy. The Bill does not use the word "or" between paragraphs (a) and (b) of section 5(5). It should.

4.24 The Bill does not make sufficient provision for the registration of vulnerable groups such as the elderly and the disabled who have transport difficulties. Why must a person register with the Fund at all? **Who will pay for the resources necessary for this registration process?**

It is an added administrative burden and cost for health care providers and health establishments. These entities need to be focused on providing health care services, not administering the NHI Fund's registers. Don't they already have patient files for those patients who come to them for treatment? Why can this data not be used to populate the NHI Fund's registers? **Personnel paid by the Fund must be responsible for the registers, not those employed by individual health care service providers and health care establishments.**

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Also, there must be a separation between purchaser and provider because providers can potentially create ghost users, such as we have seen in several other state agencies where money is at stake. There is an incentive for providers, whether public or private, to ensure that every single patient that they have ever attended is on that register whether they are still alive or not, whether they have since relocated to another province or not. **There is also considerable scope for duplication of users on the register if providers must register the user. Registration for NHI benefits is a Fund activity and responsibility.**

4.25 The proposed amendments to the Medical Schemes Act in Schedule 1 of the Bill are unconstitutional because they unfairly discriminate against pregnant women requiring pregnancy related health care services by stating that medical schemes cannot fund such services. **If a pregnant woman can afford to pay out of her own pocket for a confinement in a private hospital of her choice, why can she not do so through a medical scheme instead?** These amendments favour the very wealthy and prejudice everyone else. If everyone is paying their taxes as they should, why can they not choose to still be a member of a medical scheme and access healthcare through a route other than the Fund using their after-tax income?

4.26 What if a user requires emergency medical treatment and cannot provide proof of identity as envisaged in **section 5(8) of the Bill**? Will s/he be refused emergency medical treatment? That would be unconstitutional in terms of **section 27(3) of the Constitution. South African laws do not mandate the carrying of identification cards or documents.**

4.27 Will a person **who is not registered** as a user be refused emergency medical treatment? That would be unconstitutional in terms of **section 27(3) of the Constitution.**

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5 Principle: Constitutional Implications of the Bill For Provincial Governments

5.1 Section 227 of the Constitution states that each province is entitled to an equitable share of revenue raised nationally to enable it to provide basic services and perform the functions allocated to it. A province's equitable share of revenue raised nationally must be transferred to the province *promptly and without deduction*.

5.2 In terms of section 214(1)(a) of the Constitution, an Act of Parliament must provide for "the equitable division of revenue raised nationally among the national, provincial and local spheres of government". To comply with sections 214(1)(a) and 277 of the Constitution, Parliament annually enacts a Division of Revenue Act.

5.3 An argument could be made that the NHI Bill effectively reduces the provinces' equitable share with regard to health services so the Bill is not in violation of section 227 of the Constitution. **However, this is not what the NHI Bill says.** Section 49(2)(i) of the Bill states that the Fund will be financed *inter alia* with funds *shifted* from the provincial equitable share and conditional grants into the Fund.

5.4 Thus money will be *deducted* from the provinces' equitable share contrary to section 227 of the Constitution. Section 49(2)(i) of the Bill means that the National Treasury must still calculate the provinces' equitable share of national revenue with regard to health services but instead of paying it to the provinces, it must be paid to the NHI Fund either wholly or in part. This will affect provincial treasuries' powers to determine the allocation of that province's equitable share to various provincial functions, including the "basic services" envisaged by the Constitution. The Constitution does not define "basic services".

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5.5 Section 22 of the PFMA states that draft legislation *that excludes money from payment into a provincial revenue fund* may be introduced in Parliament only *after* the Minister of Finance has been consulted on the reasonableness of the exclusion *and has consented* to the exclusion. The BHF has no concrete evidence that the Minister of Finance has consented to of this exclusion in the Bill.

5.6 Section 227 (4) of the Constitution imposes an obligation on provinces to provide for themselves any resources that they require in terms of a provision of their provincial constitution, that are additional to its requirements envisaged in the Constitution.

5.7 Section 227(2) states that there is no obligation on the national government to compensate provinces or municipalities that do not raise revenue commensurate with their fiscal capacity and tax base. This means that if the provinces run out of money to provide "basic services" that include certain health care services, they will have to find the money themselves.

5.8 Section 228 of the Constitution allows a provincial legislature to impose taxes, levies and duties other than income tax, value added tax, general sales tax, rates on property or customs duties. A province may also impose flat rate surcharges on any tax, levy or duty that is imposed by national legislation, other than on corporate income tax, value added tax, rates on property or customs duties. There are constitutional restrictions on these powers of the provinces in section 228 but these powers do exist.

5.9 **Under section 197 of the Constitution**, provincial governments are responsible for the recruitment, appointment, promotion, transfer and dismissal of members of the public service in their administrations within a framework of uniform norms and standards applying to the public service.

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5.10 The NHI Bill attempts to create an alternative government framework for health care service delivery that significantly bypasses provincial governments. If a province's equitable share of national revenue for health care is diverted to the Fund, this means that the province, potentially, will not receive *any* funding to provide for provincial health care services from national revenue.

5.11 A province may have to be paid by the Fund in order to pay the salaries of employees working in the provincial departments of health and public health establishments and meet the other expenses of public hospitals.

5.12 Will the equitable share of the provinces always provide at least for the provincial departments of health to pay salaries and other administrative and health care related expenses? **BHF argues that it must, but the NHI Bill is silent on this issue.** The provinces equitable share must still be sufficient to maintain the purchaser/provider split within the NHI system.

Under the current system, provincial departments of health are purchasers and providers but under the NHI system they must be providers only because the national health insurance fund is the purchaser.

5.13 It is all very well to say that there is no provision in the national health insurance bill on these issues because it is a matter for other legislation and the Minister of Finance and the National Treasury. It is important to remember that the phrase "this Act" allows the Minister and the Fund to override the provisions of other legislation including the DORA. **BHF believes that the NHI bill is therefore unconstitutional with regards to its provisions concerning the equitable share of the provinces. The NHI Bill must not allow the Minister of Health to encroach on the powers of the Minister of**

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Finance neither must the Bill be allowed to override the provisions of the Constitution themselves or legislation mandated by the Constitution. All state related financial matters, including the division of revenue, must be the portfolio of the Minister of Finance, not the Minister of Health.

5.14 There are indications in the Bill that provincial departments of health will have far less control of, and responsibility for, the public health sector in the province than they have currently and that a significant number of public health establishments will become entities that are not owned or administered by the provincial departments of health at all.

5.15 The scheme envisaged by the NHI Bill raises significant barriers to the provinces obtaining the funding they need to provide "basic services" as envisaged by the Constitution. **BHF is concerned that the NHI Bill is in violation of the section 41 constitutional principle that spheres of government and organs of state must respect the constitutional status, institutions, powers and functions of government in the other spheres; not assume any power or function except those conferred on them in terms of the Constitution; and exercise their powers and perform their functions in a manner that does not encroach on the geographical, functional or institutional integrity of government in another sphere.** BHF is fully aware that the provincial departments of health will still have to provide some health care services under NHI but the amendments to section 25 of the National Health Act in the Schedule together with the transfers of the provision of health care to other entities such as the NDOH, the DHMOs and public hospitals as national public entities means that provincial government responsibility for health care services will be drastically reduced.

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5.16 The new section 25(2) of the National Health Act will read as follows –

"The head of a provincial Department must, in accordance with national health policy and relevant provincial health policy perform such health functions within the relevant province as may be prescribed."

This means that the Minister of Health will have the power to determine the functions of provincial government as far as health functions are concerned, through regulations. **BHF believes that this is a violation of the constitutional requirements of section 41 prohibiting encroachment on the functions of one sphere of government by another.**

5.17 The paragraphs under section 25(2) of the National Health Act will also be amended as follows (a strikethrough indicates deleted paragraphs) –

(a) provide specialized hospital services;

~~(b) plan and manage the provincial health information system;~~

(c) participate in interprovincial and into sectorial coordination and collaboration;

(d) coordinate the funding and financial management of district health councils;

(e) provide technical and logistical support to district health councils;

~~(f) plan, coordinate and monitor health services and must evaluate the rendering of health services;~~

(g) coordinate health and medical services during provincial disasters;

~~(h) conduct or facilitate research on health and health services;~~

~~(i) plan, manage and develop human resources for the rendering of health services;~~

~~(j) plan the development of public and private hospitals, other health establishments and health agencies;~~

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~~(k) control and manage the cost and financing of public health establishments and public health agencies;~~

~~(l) facilitate and promote the provision of comprehensive primary health services and community hospital services;~~

(m) provide and coordinate emergency medical services and forensic pathology, forensic clinical medicines and related services, including the provision of medicolegal mortuaries and medical legal services;

(n) assist the District Health Management Office in controlling the quality of all health services and facilities; (new)

(o) provide health services contemplated by specific provincial health service programmes;

(p) provide and maintain equipment, vehicles and healthcare facilities in the public sector;

(q) consult with communities regarding health matters;

(r) provide occupational health services;

~~(s) promote health and healthy lifestyles;~~

(t) promote community participation in the planning provision and evaluation of health services;

(u) provide environmental pollution control services;

(v) ensure health systems research; and

(w) provide services for the management, prevention and control of communicable and noncommunicable diseases.

5.18 It is clear from this amendment that provincial employees currently involved in -

5.18.1 promoting health and healthy lifestyles,

5.18.2 quality control of healthcare services,

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5.18.3 controlling and managing the cost of financing public health establishments and public health agencies,

5.18.4 health services and health research,

5.18.5 planning and managing and developing human resources for the rendering of health services

will all be extraneous to requirements of provincial departments of health under NHI. **This has significant labour law implications. What will happen to these employees? Why can provinces not still have managers to manage their human resources if they are providing health care services under NHI?**

5.19 **Section 32(2)(a)** of the Bill allows the Minister of Health to "delegate to provinces *as management agents*, for the purposes of provision of health care services, and in those cases the Fund must contract with *sections within the province* such as provincial, tertiary, regional and emergency medical services". The reference to "sections within the province" is confusing as its legal meaning is uncertain. In law one can only contract with *legal entities* such as a provincial government, not "sections within the province" and certainly not with a "service".

5.20 The Bill does not define what is meant by "management agents" either. Will the provincial governments be "agents" of the Minister or the Fund? Why should they be "agents" at all when they have power to act in their own right as health service providers? How is their appointment as management agents related to amendments to the National Health Act. BHF submits that section 32 of the NHI Bill is unreasonable given that the provinces will still be responsible for the provision of certain kinds of health services such as specialized hospital services and public ambulance services (section 35(4)(c)).

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The Minister already has the power under the Constitution to introduce new legislation in Parliament. He must do so following the procedures set out in the Constitution and according to the rules of Cabinet. **Section 32(2) is unconstitutional and should be deleted in its entirety.**

5.21 **Section 32(3) is also unconstitutional because it refers to the functions of a "provincial Department" not a provincial department of health.** It could mean *any* provincial department, including a provincial Treasury, education, human settlements etc. The NHI Bill cannot dictate to the Minister of Health or Cabinet what amendments they can make to existing national legislation because it unduly restricts the powers already awarded to them by the Constitution to introduce national legislation in Parliament (**see section 85(2)(d) of the Constitution**). **An ordinary Act of Parliament such as the NHI Bill cannot amend the Constitution or dictate to the President in Cabinet how the authority of the National Executive Branch of government must be exercised.**

5.22 The NHI Bill also allows the Minister of Health to designate provincial tertiary and regional hospitals or groups of hospitals as autonomous legal entities accountable to the Minister through regulation. This means that these designated provincial tertiary and regional hospitals or groups of hospitals will become legal entities in their own right purely at the discretion of the Minister of Health. This would remove them from provincial jurisdiction completely as they would be accountable to the Minister "through regulation".

5.23 **Section 41 of the Constitution** stipulates that all spheres of government and organs of state within each sphere must respect the constitutional status, institutions, powers and functions of government in the other spheres. They must also not assume any power or function *except those conferred on them in terms of the Constitution*.

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5.24 **Section 35(2)** of the Bill states that the Fund must "reimburse" payment directly to *accredited and contracted* central, provincial, regional, specialized and district **hospitals** based on a global budget or diagnosis related groups. The Bill does not define what is meant by a "global budget" or diagnosis related groups. Furthermore, this section of the Bill suggests that provincial health departments *will not be paid* by the Fund. Instead, *individual public hospitals* within the province will have their own budgets and will be paid directly by the Fund. **But provincial hospitals may not all become legal entities in their own right. The provinces will still have a duty to provide specialized hospital services in terms of the amended section 25 of the National Health Act.** The Bill is going out of its way to avoid any payments by the Fund to provincial health departments which is not only unworkable but also inconsistent with the provisions of the National Health Act.

5.25 From labour law perspective, the acquisition of legal personality by central, provincial, regional, specialized and district hospitals means that employees currently working in those hospitals will have to become employees of those hospitals instead of the provincial government. To the extent that these hospitals are awarded juristic personality in their own right, they will be able to employ people themselves. These employees might not be part of the Public Service **at all**. According to a National Treasury document titled 'Interim Guide for Creating Public Entities At The National Sphere of Government[14]

[14]https://www.treasury.gov.za/legislation/pfma/public%20entities/Interim%20Guide%20for%20creating%20public%20entities.pdf

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"PEs [Public Entities] are established in the Public Sector, **but outside the Public Service**, for reasons of –

(a) strategic, social or economic intervention by the State or to deal with strategic risks and dangers that the State or society faces to eat, security, health, prosperity or well-being; and/or

(b) adopting commercial and business principles in service delivery when it is required; and/or

(c) signaling that there is a need for objectivity and more operational autonomy, get retaining accountability in the delivery of services."

5.26 **But section 197(4) of the Constitution** states that *provincial governments* are responsible for the recruitment, appointment, promotion, transfer and dismissal of members of the public service in their administrations within a framework of norms and standards applying to the public service. Will these employees lose their jobs? Will their employment contract be transferred to these hospitals? What if the conditions of employment differ substantially from the conditions of employment under the Public Service Act?

5.27 Why should the Minister of Health be able to "designate provincial treasury and regional hospitals or groups of hospitals as autonomous legal entities accountable to the Minister through regulation" as provided in **section 32(2)(b) of the Bill** when there is already provision in the Public Finance Management Act for the creation of national public entities? What kind of public entities will these hospitals or groups of hospitals be? What is meant by "designate"? **It is constitutionally unacceptable for the Minister of Health to be able to create public entities through regulations under the National Health Act or the National Health Insurance Act.** National public entities should only be capable of creation by legislation passed by Parliament or in terms of the Public

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Finance Management Act by the *Minister of Finance*. **A member of the National Executive should never have such powers.**

5.28 The Public Service Act, which is constitutionally mandated legislation, is also relevant here. The Public Service Commission is a section 196 constitutional institution. Section 196(3) of the Constitution states that "no person or organ of state may interfere with the functioning of the Commission". Commission is accountable to the National Assembly, not the Minister of Health. **BHF submits that to the extent that the National Health Insurance Bill purports to directly or indirectly override or amend the Public Service Act, interferes with the employment contracts of employees of provincial departments of health, or excludes the jurisdiction of the public Service Commission, it is unconstitutional.**

6 Principle: The Value Of The Medical Schemes

6.1 Medical schemes have long played a vital role in easing the financial burden on government in relation to health care services. They are vehicles created by government in terms of the Medical Schemes Act No 131 of 1998 that empower people to invest some of their disposable income in their health. **This is something to be encouraged in a developing country where resources for health will always be scarce.**

6.2 Members of medical schemes pay contributions out of their *after-tax* income, i.e. their disposable income. This means that they are also taxpayers who indirectly finance the public health system. Since medical scheme membership is voluntary, it is an individual decision to be a member of a medical scheme or not. This impacts on the constitutional rights to human dignity, privacy and freedom of association. **Unjustifiable restrictions in legislation on how people spend their after tax income are unconstitutional.**

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6.3 Whilst medical scheme membership was typically a condition of employment in past decades, that has changed substantially in more recent years with employers choosing to pay cost to company-based remuneration which affords some employees more leeway in deciding how much of their remuneration package will be take home pay and how much will be in the form of employment benefits. Employers have also been subjected to increased pressure from labour in more recent years as far as employee freedom of choice of medical scheme membership is concerned. Even so, some of the employer-based medical schemes, the so-called restricted membership schemes, are some of the best and most efficiently run of all medical schemes.

6.4 There is a common misconception in the public mind that members of medical schemes are wealthy. Most scheme members are not wealthy, they are employed. The concept of wealth is relative. To the poor, a medical scheme member earning R20 000 per month may seem wealthy but in reality that member is barely scraping by.

6.5 They must incur transport costs in getting to work, they have to dress appropriately for work, they have families - *often extended families* - to support, school fees to pay, electricity and water bills, rates and taxes, mortgages, car licence fees etc.

These are living expenses a majority of the poor simply do not have. In addition, these medical scheme members have to pay personal income tax, tax on fuel, and VAT. The interests of the workers in receiving health care services are just as valid as those of the poor. **The wellbeing of employees, or workers, is vital to the economy because these people are South Africa's tax base.**

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6.6 Total employment in South Africa decreased by 94 000 between December 2021 and December 2022. The unemployment rate was 42.6% in 2022[15].

6.7 As of June 2023 the average monthly salary in South Africa was R25 304, down 2.7% from the first quarter of 2023 when it was R26 002. Data published by the University of Cape Town's Liberty Institute of Strategic Marketing showed that a household needs to earn around **R22 000** to be considered middle class in South Africa[16].

6.8 The average salary in South Africa was **R26 032** in the fourth quarter of 2022 as reported by Stats SA (Quarterly Employment Survey or QES). The QES data differs from the Quarterly Labour Force Survey (QLFS) in that the QES data reflects the number of people receiving salaries and does not reflect employment/unemployment trends like the QLFS[17].

6.9 While medical scheme membership is currently encouraged by the tax laws in the form of a Medical Scheme Fees Tax Credit, there is a low ceiling on these rebates. Typically, the Tax Credit does not equate to even half the amount of a medical scheme contribution.

For example, in 2023 the medical tax credit rate for the member of a medical scheme was R347 and in 2024 will be R364[18]. **Even if the employer subsidises the contribution, the tax credit is typically not a full rebate on the amount of the contribution currently paid by an employee.** The government has not allowed

15 https://www.rateweb.co.za/career-advice/average-salary-in-south-africa-for-2020/
16 https://businesstech.co.za/news/wealth/699287/the-average-salary-in-south-africa-right-now/
17 https://www.rateweb.co.za/career-advice/average-salary-in-south-africa-for-2020/
18 https://www.sars.gov.za/tax-rates/medical-tax-credit-rates/; see also https://www.sars.gov.za/wp-content/uploads/Ops/Guides/PAYE-GEN-01-G18-Guide-for-Employers-iro-Employees-Tax-for-2024-External-Guide.pdf

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medical schemes to offer Low Cost Benefit Options that would have helped employees earning lower incomes who would have truly benefitted from the Medical Tax Credit due to the lower contributions payable.

6.10 The NHI system proposes to do away with this subsidy but will it be able to provide benefits to medical scheme beneficiaries equivalent to or better than those currently provided by medical schemes in terms of **quality** of health care services, **accessibility** of health care, negligible **waiting periods** for access to health care, same day access to medicines etc.?

6.11 **Medical schemes are legally obliged to pay for minimum benefits prescribed in regulations to the Medical Schemes Act** (the prescribed minimum benefits or PMBs). The Council for Medical Schemes reported in 2020, now three years ago, the average contribution per beneficiary per month **for just the PMBs** was R866.02[19]. Medical schemes have been pushing for the revision of PMBs for years but that has not happened either, despite the fact that it is required by regulations under the Medical Schemes Act. Yet many like to point to the medical schemes industry and blame it for the problems, while the Medical Schemes Act No 131 of 1998 was created by the new, constitutional government.

6.12 It is conveniently forgetten that medical schemes have been arguing for years that the PMB package is too expensive and that it is blocking medical schemes from benefiting lower income earners who want access to health care in the private sector. **The Competition Commission's Health Market Inquiry made no bones about government's stewardship failure over the private health sector as a significant contributor to the high prices of health care in that sector.**

[19] https://www.medicalschemes.co.za/the-medical-schemes-industry-in-2020/#1634553493206-50841b4e-4f6e

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6.13 The government has previously recognized the legitimacy of medical schemes primarily through the Medical Schemes Act but also in the National Health Act No 61 of 2003. **Section 4(3)** of the NHA states with regard to free health services in public health establishments that –

"Subject to any condition prescribed by the Minister, the state and clinics and community health centres funded by the state must provide-

(a) pregnant and lactating women and children below the age of six years, *who are not members or beneficiaries of medical aid schemes*, with free health services

(b) all persons, *except members of medical aid schemes and their dependants* and persons receiving compensation for compensable occupational diseases, with free primary healthcare services;"

6.14 There is no proposed amendment of **section 4 (3)** of the National Health Act in the Schedule to the NHI Bill. **Section 4(3) of the NHA must be deleted in the Schedule to the NHI Bill so as not to unfairly prejudice medical scheme beneficiaries.**

6.15 The upshot of all this is that members of medical schemes currently have to pay for public health care services if they wish to access them. **Even if they are not members of medical schemes, they would be charged as private patients by public hospitals due to the means test currently applied.**

6.16 Whilst primary healthcare services may not cost much in fees, they do cost patients who are employed and their employers, or those running private businesses, **more than just the fees**.

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6.17 **Lengthy waiting times** at clinics, community health centres and public hospitals can cost patients who are paid by the hour dearly. They also cost employees and employers in sick leave or, if sick leave has been used up, annual leave. **Therefore, accessing the public health sector has hidden but material costs for those who are employed or run their own businesses.**

6.18 Public sector patients typically do not have the luxury of consulting with a health care professional outside of normal working hours. **Primary health care clinics have been severely criticized in the past for adhering strictly to working hours**. But if the majority of them do not work, this is not such a problem. **It is a completely different story for those who are employed.** Sick leave and annual leave are restricted and valuable commodities to an employed person. If sick leave and annual leave runs out **they are subject to unpaid leave which can further impoverish them.**

6.19 The considerable value added by medical schemes to the economy is underappreciated because the media often highlights only the few hard cases, not the many thousands who are satisfied with the health care that they receive from the private sector. In a 2010 study[20], 84.6% of those who used public providers were somewhat satisfied to very satisfied while users of the private health sector were 97.3% satisfied. The authors note, however, that satisfaction rates alone are not evidence of high-quality care. Patients' impressions of the quality of care are likely to be based primarily on good interpersonal communication with the clinicians but patients have a poor ability to rate their providers' technical skills.

[20] Jacobsen K H and Hasumi T, 'Satisfaction with health care services in South Africa: results of the national 2010 General Household Survey' Pan Afr Med J, 2014; 18:172 https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4239447/

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6.20 While it is not without its challenges **and the private sector does need to be properly regulated by government,** this sector serves to retain and sustain private health care professionals and private hospitals and encourage foreign investment in the economy. **This creates jobs and employment opportunities that would not otherwise exist.**

6.21 The cost of health care is too great for public funding alone. **It is reported that in Ghana, which has already introduced a National Health Insurance scheme, the most dynamic growth and most exciting commercial opportunities are to be found in privately funded hospitals and clinics and in the non-state-controlled portion of the pharmaceutical sector**[21]. There will always be people willing to take responsibility for their own health care needs and purchase the services that they want and need.

6.22 Even if the public sector in South Africa provides the majority of health care services for its population, which it does even now prior to NHI, **there is still room for a thriving private sector in South Africa's economy.** The South African economy cannot afford to lose jobs, current health care investments and major businesses.

In the past the private health sector has stepped into the breach and assisted the public health sector with hospital beds, the administration of COVID-19 vaccines etc. **The private health sector in South Africa is an asset and must not be sacrificed in favour of NHI.**

6.23 The NHI in South Africa will never have access to unrestricted funding because there is a limit at which taxation becomes destructive to an economy by forcing people into poverty.

[21] https://www.trade.gov/country-commercial-guides/ghana-healthcare

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The expression "taxed to death" can become quite literally true. **South African economist Mike Schussler has said that South Africa already carries some of the highest tax rates in the world and hiking these will only serve to further stifle growth**[22].

6.24 **All countries, even developed countries, have mixed health care systems that include a private and public sector.** In developing countries where economies are weak the private sector plays an especially vital role in widening access to health care services.

CONCLUSION

7.1 The fact that so many questions arise from the provisions of the NHI Bill is itself indicative of the fact that the Bill is at best incomplete and at worst ill conceived. **It does not comply with the constitutional requirement of legal certainty.** For that reason alone it is unconstitutional.

7.2 BHF made detailed written comments on the first draft of the National Health Insurance Bill, only to be told by the Parliamentary Portfolio Committee on Health at its oral hearing that the Committee **had not read BHF's submission.** BHF regards this as a direct violation of its constitutional right to participatory democracy.

7.3 As a result of time constraints, BHF has not gone to the same lengths as it did its submission on the first draft of the Bill. Its efforts were treated dismissively and with contempt by the

[22] https://businesstech.co.za/news/finance/233199/the-highest-income-tax-rates-in-the-world-including-south-africa/

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Parliamentary Portfolio Committee of Health. **However, it warns that there are other defects in the NHI Bill** that BHF has not included in this submission.

7.4 BHF would be happy to answer questions and clarify any points made in this submission in oral hearings or any other forum created for this purpose.

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