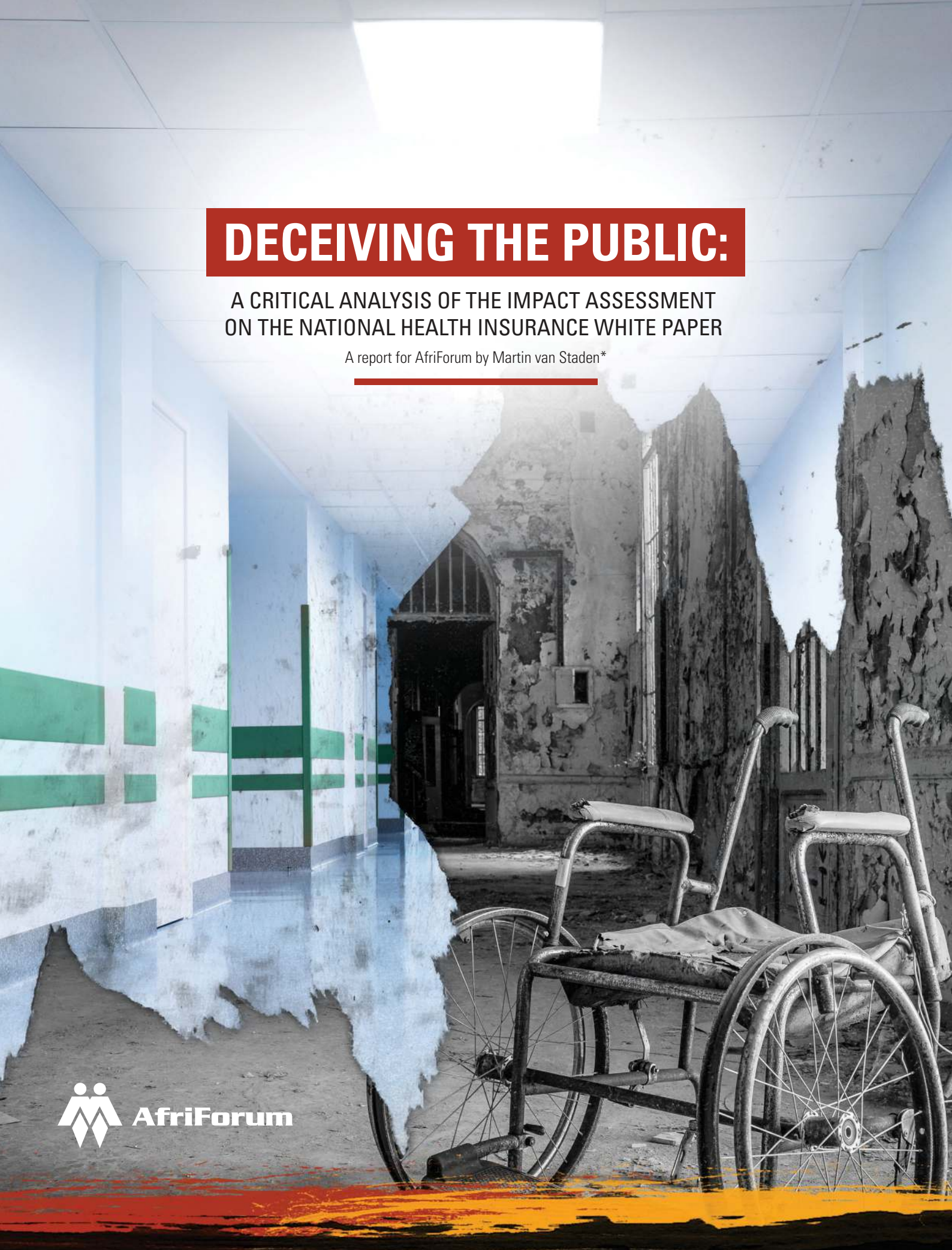
# DECEIVING THE PUBLIC:

## A CRITICAL ANALYSIS OF THE IMPACT ASSESSMENT ON THE NATIONAL HEALTH INSURANCE WHITE PAPER

A report for AfriForum by Martin van Staden*



AfriForum

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## ABSTRACT

Impact studies are an important characteristic of well-considered public policy. In their absence, government conduct might be whimsical and have no relation to reality. But impact studies themselves can be used to deceive, especially when they are intellectually dishonest and partial. This is exactly what the National Health Insurance Bill, and the White Paper policy underlying it, is based on: A poorly drafted impact study tainted by bias, replete with uncited assertions and glaring omissions. These flaws amount, at best, to a negligent misrepresentation of the true impact of the NHI and, at worst, to a fraudulent deception perpetrated upon the South African public. South Africans must insist that a proper, independent study be done, factoring in dwindling economic performance, a shrinking tax base and a corrupt and inefficient government, to provide a clear indication of whether the NHI is workable and affordable. With such a shaky foundation in the impact study, the current NHI scheme is clearly not supported by reason or evidence and should ideally be set aside.

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## ACRONYMS USED IN THIS REPORT

**DPME** – Department of Planning, Monitoring and Evaluation

**GDP** – Gross domestic product

**NHI** – National Health Insurance

**RWOPS** – Remunerated work outside of public service

**SEIA** – Socio-economic impact assessment

**SEIAS** – Socio-Economic Impact Assessment System

## 1. INTRODUCTION

On 30 August 2019, the Department of Health made the National Health Insurance Bill available for public comment. The Bill is the latest proposal in a 15-year process to adopt a public health insurance scheme for South Africa. It is the second version of the Bill and is based on the 2017 National Health Insurance White Paper[1] – government's official policy statement.

In 2015, the Department of Planning, Monitoring and Evaluation (DPME) adopted the Socio-Economic Impact Assessment System (SEIAS) Guidelines. These guidelines set out the formula and theory of assessments that must be conducted when any new intervention – be it a policy, regulation or legislation, etc. – is considered.[2] Properly conducted impact assessments are not only factors of good law- and policy-making,[3] but are, it is submitted, imperatives of both the Constitution and the rule of law.[4]

The 2017 National Health Insurance White Paper, as required, was accompanied by a socio-economic impact assessment.[5] The 2019 version of the National Health Insurance Bill, however, was not, despite the requirement.

The first part of the present analysis will briefly explain the constitutional imperative of impact studies. The second part will set out the characteristics of a good socio-economic impact assessment (SEIA), and the third part will consider the material faults in the National Health Insurance White Paper SEIA. These faults are categorised, firstly, according to their failed adherence to international SEIA standards, and secondly, according to their partiality, imbalance and intellectual dishonesty.

Among its most damning shortcomings is the fact that the drafters of the assessment did not consider any alternatives to the proposed National Health Insurance (NHI) scheme, which is a crucial aspect of a good impact assessment. It was assumed ab initio that the Department of Health's proposal was the best and only option. The SEIA also does not consider the

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1 Department of Health. 2017. *National Health Insurance for South Africa: Towards universal health coverage*. Pretoria: Department of Health.

2 Department of Planning, Monitoring and Evaluation. 2015. *Socio-economic Impact Assessment System (SEIAS) Guidelines*. Pretoria: DPME, p. 3.

3 Law Review Project. 2013. *Good law guidelines, principles, and values*. Johannesburg: Law Review Project, p. 34.

4 Van Staden M. 2019. *The Constitution and the rule of law: An introduction*. (2019). Johannesburg: FMF Books, pp. 119–122. Available at: https://ruleoflaw.org.za/wp-content/uploads/2019/02/Van-Staden-The-Constitution-and-the-Rule-of-Law-2019.pdf.

5 Director-General: Health. 2017. *Socio-economic Impact Assessment System (SEIAS): Final impact assessment (phase 2): White Paper on National Health Insurance*. Pretoria: Department of Planning, Monitoring, and Evaluation.
It is notable that it was also required to conduct an impact assessment on the NHI Bill itself, but no such assessment can be found.

constitutional or moral implications of divesting South Africans of their right to have access to private medical schemes, nor does it engage critically with the indisputable fact that the fiscus cannot support a scheme on the scale of the NHI.

These and the many other faults discussed below potentially undermine the whole NHI scheme from an evidentiary as well as a legal-constitutional perspective. If the premises of the assessment are erroneous, which it is submitted they are, the assessment's conclusions, used to justify the NHI scheme, are also erroneous. This fact taints the public participation process as well as all the justifications the Department of Health has relied on to advocate the adoption of the NHI Bill.[6]

## 2. THE NECESSITY OF IMPACT ASSESSMENTS IN PUBLIC POLICY

### 2.1 Constitutional basis for impact assessments

There are various provisions in the Constitution that can reasonably be interpreted to oblige government to undertake impact assessment studies. According to the Constitutional Court in *S v Makwanyane*, the Constitution must be read as a whole, and no provision can be construed in isolation from all the others.[7] In this light, the following provisions, if read together, require of government to undertake and publish, in a timeous fashion, honest impact assessments on its proposed interventions.

Section 1 of the Constitution sets out the founding values of the South African constitutional order. According to it, South Africa is founded, among other things, on an "open government".

Section 41 concerns the principles of co-operative governance and provides that organs of State in each sphere of government must "provide effective, transparent, accountable and coherent government for the Republic as a whole".

Section 57 governs the internal arrangements of the National Assembly, and obliges the National Assembly, when it makes rules, to have "due regard to representative and participatory democracy, accountability, transparency and public involvement". This is repeated in section 70, which governs the National Council of Provinces.

Section 59 mandates public access to the National Assembly and provides that the public and media may not be excluded from the "sitting of a committee unless it is reasonable and justifiable to do so in an open and democratic society".

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6 Hereinafter the NHI White Paper and NHI Bill are collectively referred to as the "NHI scheme".
7 *S v Makwanyane and Another* 1995 (3) SA 391 (CC) at para 10.

Section 195 sets out the principles that are supposed to govern public administration. It provides that all organs of State must foster transparency by providing the public with timely, accessible and accurate information.

### 2.2 Impact assessments as an imperative of the rule of law

Section 1(c) of the Constitution incorporates into South African constitutional law the doctrine of the rule of law, by providing that South Africa is founded upon the supremacy of both the Constitution and the rule of law. The rule of law, as a jurisprudential doctrine, prohibits arbitrariness on the part of government, and excludes unpredictability and irrationality in the formulation of law and policy.

The most important characteristic of the rule of law is its aversion to arbitrariness. Arbitrariness is the quality of something, within the relevant context, being unreasonable, badly reasoned or simply whimsical. In the realm of public policy, it is not only unfair and indicative of bad governance, but it more often than not entails bad outcomes for that relevant area of society that is being regulated, and for the economy more broadly.

The rule of law, therefore, encourages reasonableness in public and legal policy – the opposite of arbitrariness. Cora Hoexter, albeit in the context of administrative law, argues that reasonableness consists of two elements: Rationality and proportionality. Proportionality means that there must not be an imbalance between the adverse consequences of a policy and its beneficial consequences. Rationality means that there must be evidence that supports the policy. Stated differently, there must be a rational connection between the problem the policy wishes to solve, and the solutions proposed to solve it. It has also been said that a third element, effectiveness, is a part of reasonableness.[8]

Section 195(1)(g) of the Constitution provides that all organs of State must foster transparency by providing the public with timely, accessible and accurate information. This constitutional imperative, read with the requirement of rationality, clearly requires interventions to be supported by demonstrable evidence.

This requires a study that sets out the expectations and potential unforeseen consequences of the intervention. Without such a study, the imperative of transparency cannot be satisfied, and the imperative of rationality can also not be satisfied, as it means the intervention is not supported by the available evidence, but rather whimsical. The result is that such an intervention is unconstitutional.

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8 Hoexter, C. 2012. *Administrative Law in South Africa*. Cape Town: Juta, p. 344.

## 2.3 Socio-Economic Impact Assessment System

In 2015, the DPME published its SEIAS guidelines. It is made clear that a SEIA must be conducted on every intervention, including legislation, policies and regulations.[9] In these guidelines, the DPME describes the purpose of the SEIAS *inter alia* as follows:

> To minimise **unintended consequences** from policy initiatives, regulations and legislation, including unnecessary costs from implementation and compliance as well as from unanticipated outcomes.
>
> To anticipate implementation risks and encourage measures to mitigate them.[10]

The DPME acknowledges that interventions can lead to unintended consequences. This may be a result of inefficiency, excessive compliance costs, overestimation of the benefits associated with the intervention, or an underestimation of the risks involved with the implementation of the intervention.

While the guidelines acknowledge that some interventions are important enough to implement even if there will be unintended consequences, the DPME nonetheless requires that such unintended consequences be *considered and stated*.[11]

The DPME regards a SEIA as more than a mere cost-benefit analysis. Instead, these assessments must contribute to improving the quality of the interventions, rather than merely measuring their net value. It must, furthermore, "help decision makers to understand and balance" the impact of interventions on different groups within society.[12]

The DPME also acknowledges the harm that can be done by bestowing unrestrained discretionary or delegated law-making powers upon officials in interventions:

> A less easily identified cost arises when an implementation mechanism opens the door to corruption. It is important to ensure that proposals provide adequate controls on the discretion of individual officials to benefit or harm the public or enterprises. These controls typically take the form of clear criteria for official decisions; requiring officials to publish their decisions and justify them in terms of the criteria provided; and establishing an easily accessible and fair appeals route.[13]

In other words, in the conducting of a proper SEIA, attention must be paid to how discretion is circumscribed.

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9 Department of Planning, Monitoring and Evaluation (footnote 2 above), p. 8.
10 Department of Planning, Monitoring and Evaluation (footnote 2 above), p. 4. My emphasis.
11 Department of Planning, Monitoring and Evaluation (footnote 2 above), p. 4.
12 Department of Planning, Monitoring and Evaluation (footnote 2 above), p. 7.
13 Department of Planning, Monitoring and Evaluation (footnote 2 above), p. 5.

# 3. CHARACTERISTICS OF A GOOD SOCIO-ECONOMIC IMPACT ASSESSMENT

## 3.1 International standards

According to its best-practice guide on regulation, the Australian government requires every government intervention in the economy to be accompanied by a regulatory impact statement. Interventions must be based on, among other things, the following principles (which the impact assessment must show): Regulation must not be the default option, regulation must only be imposed when government can show it will offer an overall net benefit, the cost burden of the new intervention must be fully offset by reductions in the existing regulatory burden, and interventions must be implemented with common sense, empathy and respect.[14] According to the Finnish government's guidelines on impact assessments, these studies are meant to "increase the transparency of regulatory drafting and decision-making and thereby also the credibility of the decision-makers".[15] Regulatory impact statements must ask, and adequately answer, the following questions:[16]

1. **What is the problem being addressed?** The problem must be clearly explained.
2. **Why is government action necessary?** Is this a genuine priority, and, in particular, is it government's job to solve this problem? Will the intervention succeed in solving the problem?
3. **What other policy options are available?** All the viable options – including not intervening in the first place – must be considered. The Finnish government's guidelines put it as follows:

   > "[…] regulation is not always the sole available means to achieve social reform. In given instances, e.g. publicity, education, business self-regulation or attitude adjustments may be far more effective vehicles for social change than regulation can ever be."[17]

4. **What are the benefits of each option?** If the burden imposed by the intervention is "greater than the benefit, you should look for alternatives or reconsider the need to intervene at all". The Finnish guide says that the greater the anticipated impact of an intervention, the greater the detail the impact assessment must provide on that aspect of the intervention.[18]

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14 Department of the Prime Minister and Cabinet of Australia. 2014. *The Australian Government guide to regulation*. Canberra: Government of Australia, p. 2.
15 Ministry of Justice of Finland. 2008. *Impact assessment in legislative drafting: Guidelines*. Helsinki: Ministry of Justice, p. 10.
16 Department of the Prime Minister and Cabinet of Australia (footnote 14 above), p. 5–7.
17 Ministry of Justice of Finland (footnote 15 above), p. 9.
18 Ministry of Justice of Finland (footnote 15 above), p. 10.

5. **Who will be consulted and how?** Transparency and accountability to those who will be affected are key.
6. **What policy option is the best?** The public must know why this particular intervention was chosen: Based on what information and arguments? The Finnish guide says:

   > "It is […] necessary for the decision-maker to supply reasons for the choice of a given alternative or approach."[19]

7. **How will the chosen option be implemented and evaluated?** Whether the intervention will work in the real world must be borne in mind.

In summary:

> Every policy option must be carefully assessed, its likely impact costed and a range of viable alternatives considered in a transparent and accountable way against the default position of no new regulation.[20]

Impact assessments must, therefore, enable stakeholders to understand the intervention and its *raison d'être*, and how it will affect them. They must also enable the identification of unintended consequences.[21]

These considerations from the Australian government will guide this analysis of the NHI impact assessment. In addition, however, it is submitted that an additional three broad characteristics of a good SEIA are imperative: Neutrality, balance and intellectual honesty. These three interrelated characteristics determine whether an impact assessment that ticks all the technical boxes of what such an assessment is meant to do, is also a *good faith* assessment.

### 3.2 Neutrality

The Australian government's guide makes the mistake of requiring that the policymakers themselves be the ones to conduct the impact assessment on their own proposed interventions.[22] This is, on its face, counter intuitive. The sponsors or drafters of the intervention have a professional vested interest in that intervention being seen in the best possible light and consequently adopted. When impact assessments are conducted by interventions' own advocates, one is faced with the problem of selection and confirmation bias.

Confirmation bias is described as follows:

> Confirmation bias occurs from the direct influence of desire on beliefs. When people would like a certain idea/concept to be true, they end up believing it to be true. They are motivated by wishful

19 Ministry of Justice of Finland (footnote 15 above), p. 10.
20 Department of the Prime Minister and Cabinet of Australia (footnote 14 above), p. 4.
21 Law Review Project (footnote 3 above), p. 36.
22 Department of the Prime Minister and Cabinet of Australia (footnote 14 above), p. 8.

> thinking. This error leads the individual to stop gathering information when the evidence gathered so far confirms the views (prejudices) one would like to be true.[23]

Applied to impact assessments, where there is confirmation bias, the drafters would gather only the information and research that confirm their existing beliefs.

Selection bias is a related notion, and is described as follows:

> Statistical error that causes a bias in the sampling portion of an experiment. The error causes one sampling group to be selected more often than other groups included in the experiment. This may produce an inaccurate conclusion if the selection bias is not identified.[24]

Similar to confirmation bias, applied to impact assessments, selection bias would make the drafter select only that information, research and phenomena toward which they have a pre-existing affinity or disposition.

Both these biases result from having a vested interest in the intervention.

When an advocate, usually the department or agency that has drafted or sponsored the intervention, conducts their own impact assessments, they go to great lengths to emphasise, in usually generous detail, the benefits of the intervention, usually underlined by the ostensible moral necessity of having that intervention adopted. A common trope is for "the public" or "the poor" to be listed as the main beneficiaries of (and never the group most disadvantaged by) the intervention. The disadvantages of and viable arguments against the intervention are usually only mentioned in passing, if not dismissed outright.

Third parties can also be partial. It makes no difference, for instance, whether the Department of Transportation or the civil society Lower Speed Limits Coalition conducts the impact assessment on whether to increase the speed limit from 100 km/h to 120 km/h. While third parties are certainly more functionally independent, which is a necessity, they can nonetheless still be ideologically aligned with or opposed to the intervention.

It is not necessarily a problem for advocates, like the policymakers themselves or partial third parties, to conduct initial impact assessments on their favoured interventions. Indeed, the more impact assessments done, the better, as this would provide the public with much relevant information from different perspectives. But the final, conclusive, or main assessment must ideally be as neutral as can be. An independent and impartial assessor with no, or at least a

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23 Heshmat S. 2015. What is confirmation bias? Available at: https://www.psychologytoday.com/us/blog/science-choice/201504/what-is-confirmation-bias.

24 "Selection bias". *Business Dictionary*. Available at: http://www.businessdictionary.com/definition/selection-bias.html.

very limited, vested interest, should conduct the study on proposed interventions, particularly if that assessment was commissioned by and carries the endorsement of government.

### 3.3 Balance

Impact assessments must give due consideration and recognition to all the sides in the discourse surrounding the intervention. Small and macro-businesses, civil society organisations involved in the debate, and other interested persons must be consulted, and their responses must be accurately and comprehensively recorded and responded to. The assessment must, in other words, give an accurate bird's-eye view of all the relevant perspectives, and not try to create the impression that there is only one dominant or legitimate view on the matter.

Another consequence of confirmation and selection bias – as a result of having a vested interest – thus, is that only one side of the discourse is given adequate elaboration and explanation in impact assessments.

### 3.4 Intellectual honesty

Authoritative sources must be cited for every substantive claim made in the impact assessment. If not, then a very strong and elaborate argument must be made for why the claim is correct. Crucially, the impact assessment must not ignore viable arguments that have been made against the intervention. According to the Australian guide, "Do not pass off opinion as fact; check the accuracy of every claim and where the facts may be inconclusive, say so".[25]

Particular constitutional values cannot be ignored in favour of others. For instance, South Africa has a tripartite set of values – freedom, equality and human dignity – that are stated throughout the Constitution, not only as founding values, but also as factors that count against the limitation of rights. Yet, in many impact assessments, human dignity and certainly freedom are unstated if not completely ignored in favour of (the achievement of substantive) equality. Similarly, the right to equality in section 9 and certain socio-economic rights in section 27 of the Constitution are often taken as the basis of interventions, whereas rights such as the right to freedom of association in section 18 and freedom to choose one's trade or occupation in section 22 are almost universally ignored.

The rule of thumb is that if the question "But why?" can be asked too easily at the end of a claim or assertion in the impact assessment, there is a lack of intellectual honesty.

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[25] Department of the Prime Minister and Cabinet of Australia (footnote 14 above), p. 14.

# 4. THE NATIONAL HEALTH INSURANCE'S DECEITFUL IMPACT ASSESSMENT

The National Health Insurance White Paper's socio-economic impact assessment fails on every metric of a good impact assessment as discussed above. Neutrality is completely absent in that the SEIA drafters – the office of the Director-General of Health – were not independent and certainly not impartial.[26] It is also left wholly unclear when the SEIA is simply restating the policy of the Department of Health, and when it is evaluating or assessing the policy.[27] There is no talk of balance, as the entire SEIA is essentially an advertisement for the NHI, as opposed to a balanced consideration of all perspectives and alternatives. Finally, the SEIA is intellectually dishonest in various respects. These flaws – usually manifested in omissions that properly should have been considered in the assessment – are considered below.

## 4.1 Good impact assessment checklist

### *4.1.1 What is the problem being addressed?*

The impact assessment does, in some detail, explain the problem government wishes to address. This "problem", however, is largely manufactured. The assessment, and government's policy, has problematised the inequality that exists between the public and private sectors, rather than the separate issue of low levels of quality outcomes in the public sector. Indeed, the assessment had to show *why* the "problem" it has identified is, in fact, a problem,[28] but did not do so. The inequality between the two sectors is simply assumed to be a problem, with the NHI's proposed amalgamation of the two sectors assumed to be the solution.

### *4.1.2 Why is government action necessary?*

Why *government* action is necessary is left entirely unanswered by the Director-General's office. It is simply assumed that government, as opposed to healthcare users themselves, bears the primary responsibility for healthcare in South Africa. It is also errantly assumed that government is best placed to oversee and manage the healthcare sector.

Section 27(1)(a) of the Constitution, which provides for the right to have access to healthcare, does not necessitate a government-led healthcare sector.

It does not follow that it is government's responsibility to solve the problem identified, nor is government best placed to solve this problem, given existing evidence to the contrary. In other

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26 Hereinafter the drafters of the SEIA will be referred to as the "Director-General". This designation refers to the office of the Director-General, particularly the staff involved in conducting the assessment, and not to the official who carries the title of Director-General.

27 For the purposes of this analysis, it is assumed at all junctures that the Director-General is engaged in evaluation – the purpose of a SEIA – rather than mere descriptive reproduction.

28 Department of the Prime Minister and Cabinet of Australia (footnote 14 above), p. 17.

words, the likelihood of the intervention – the NHI – failing, is exceedingly high, in light of government's existing record. There exist far more rational avenues for solving South Africa's health crisis that government could support.

### *4.1.3 What other policy options are available?*

The SEIA at no point considers any alternative policy option to the NHI. Vouchers are the only notable alternative to the NHI scheme mentioned in the impact assessment (on page 19), not by the Director-General or the Department of Health, but by critics, and are rejected offhand without argument. As will be seen in the following questions, this omission lethally taints the whole assessment.

### *4.1.4 What are the benefits of each option?*

The Director-General goes into detail about the ideal and hypothetical benefits of the NHI – most, if not all of which will not be realised – but given that no other policy options were considered, there is nothing to compare these ostensible benefits to.

The Australian guide explains that if the burden imposed by the intervention exceeds the benefits generated by it, alternatives *must* be considered, including the alternative of not intervening at all. The Finnish guide explains that the more severe of an impact an intervention is expected to have, the more detail and argument is required in the impact assessment.

It is trite that the burden imposed by the NHI will have severe repercussions – like the guaranteed destruction of the medical aid industry[29] and the possibility of an exodus of healthcare professionals from South Africa[30] – which, it is submitted, far outweigh the hypothetical benefits of the scheme. But the impact assessment skims over this, focusing on benefits and at best mentioning the negatives of the NHI only in passing.

### *4.1.5 Who will be consulted and how?*

Mokoko Sebola writes of public participation as follows:

> […] mere passive involvement of the people in government activities does not align with the definition [of public participation]. […] It can be concluded that in any form of public engagement in

[29] Buthelezi L. 2019, August 15. National Health Insurance will kill medical schemes, says institute. *Business Day*. Available at: https://www.businesslive.co.za/bd/national/health/2019-08-15-national-health-insurance-will-kill-medical-schemes-says-institute/.

[30] BusinessTech. 2019, October 20. South Africa is facing a doctor shortage – here's why. *BusinessTech*. Available at: https://businesstech.co.za/news/government/346538/south-africa-is-a-facing-a-doctor-shortage-heres-why/.

> which public influence is not considered, no public participation can be claimed to have taken place.[31]

Elsewhere, the Constitutional Court said as follows:

> Public involvement cannot be meaningful in the absence of a willingness to consider all views expressed by the public. […] The facilitation of public involvement is aimed at the Legislature being informed of the public's views on the main issues addressed in a bill, not at the accurate formulation of a legally binding mandate. Consultation requires the free expression of views and the willingness to take those views into account.[32]

The office of the Director-General is relatively transparent about how in the SEIA it effectively disregarded all those who objected to the NHI scheme and considered all those who agreed with it. As such, the Department of Health did "consult" to the extent that they recorded the objections, but they did not consult in a *bona fide* way in that they rejected those objections offhand. This is not to say that objectors had to be accorded veto power over the department's proposals, but rather that the department had to provide considered reasons for why it rejected the objectors' perspectives. It did not do so, except to the extent that it was cynically stated that the objectors' proposals did not align with government's ideological goals.

#### *4.1.6 What policy option is the best?*

Without having considered any alternatives, it was impossible for the Director-General to compare and contrast the various policy options. It was simply assumed that the NHI scheme was the best, without having looked at other, better options, like healthcare vouchers. The assessment does not explain why no alternatives were considered.

#### *4.1.7 How will the chosen option be implemented and evaluated?*

The impact assessment does make some ado about implementation and evaluation, but ignores the question of affordability, a facet of implementation, almost entirely. There is an attempt between pages 26 and 34 to quantify the cost of the NHI, but at no point is the unavoidable reality articulated: The NHI is unaffordable.

Former health minister Aaron Motsoaledi averred that the NHI would cost around R259 billion – more than his entire department's 2019/2020 budget allocation of R226 billion – but the

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31 Sebola M.P. 2016. Public participation in South Africa's policy decision-making process: The mass and the elite choices. *International Public Administration Review* **14**(1), pp. 55-73.

32 *Merafong Demarcation Forum and Others v President of the Republic of South Africa and Others* 2008 (10) BCLR 969 (CC) at paras 51 and 53.

exact figure was unknown to him.[33] In the 2019 midterm budget statement, it was revealed that there was a R50 billion tax collection shortfall, despite the tax increases over recent years.[34] In other words, even at the conservative estimate of R259 billion – and other, more considered estimates put the number closer to R450 billion – which would be *additional* spending by government, government is around R310 billion away from being able to afford the scheme, and its revenue is certainly not increasing year on year. It is likely that for the NHI to become temporarily affordable, government would need to appropriate the required funds from other areas of State spending, like policing and social welfare grants.

The Department of Health, however, has remained blissfully unconcerned with the cost of the NHI scheme, with the NHI Bill – which was not accompanied by the required impact assessment – being uncosted.[35] Motsoaledi himself was reported to have said one cannot be concerned with costs when talking about healthcare interventions to save lives.[36] This worrying lack of concern about cost is explained partially in the assessment, on page 26, where the Director-General states that:

> … focusing on the question of 'what will NHI cost' is the wrong approach as it is better to frame the question around the implications of different scenarios for the design and implementation of reforms to move toward [universal health coverage].

In other words, to the Director-General, the ends justify the means. Instead of concerning itself with the means – the unaffordable price-tag associated with the NHI – the public must instead focus on government's noble intentions. The impact assessment at no point engages critically with this ridiculous line of argument. But that is not surprising in this instance, as this statement in the impact assessment is a verbatim reproduction from the NHI White Paper – the very thing the assessment is supposed to critically appraise.[37]

Despite this, it is widely acknowledged in the assessment and the NHI Bill that taxes will need to be increased to pay for the intervention.

On page 12, the Director-General claims that with South Africa's broad tax base that will be expected to pay for the NHI scheme, healthcare costs for households and individuals will be reduced. This statement, if it was true in 2017 – which is doubtful – is no longer true in 2019.

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33 Daniel, L. 2018, July 2. Aaron Motsoaledi admits R259 billion NHI figure a thumbsuck. *The South African*. Available at: https://www.thesouthafrican.com/news/motsoaledi-admits-r259-bn-nhi-figure-a-thumbsuck/.

34 Cronje, J. 2019. SA looking at R50bn tax revenue shortfall – Momentum". *fin24*. Available at: https://www.fin24.com/Budget/sa-looking-at-r50bn-tax-revenue-shortfall-momentum-20191015.

35 Donnelly L. 2019, August 16. NHI: the good, the bad, the ugly. *Mail & Guardian*. Available at: https://mg.co.za/article/2019-08-16-00-nhi-the-good-the-bad-the-ugly.

36 Daniel, L. (footnote 33 above).

37 Department of Health (footnote 1 above), p. 39.

On page 36, the assessment itself notes that periods of economic downturn threaten the ability of government to raise taxes to pay for the NHI. Government, as it stands, is unable to meet its revenue targets. Increasing taxes will not solve this problem, as South Africa has already passed over the Laffer curve – tax collection will now only decrease unless tax rates and burdens are significantly reduced.[38] The burdens the NHI places on the healthcare industry, in other words, will increase prices without the expected concomitant increase in accessibility resulting from cross-subsidisation.

## 4.2 Partiality

The impact assessment was conducted in the office of the Director-General of Health, the most senior professional institution in the Department of Health, the NHI scheme's sponsor. Unsurprisingly, the partiality of the Director-General in favour of the NHI scheme is evident throughout the assessment.

### *4.2.1 Costs and benefits*

There is an overriding focus on the "intended outcomes" – the foreseen benefits – of the NHI throughout the SEIA. There is scant consideration of the anticipated disadvantages. Worst of all, there is no consideration of the potential *unintended* consequences. The potential exodus of medical professionals should the NHI be implemented, for instance, is not mentioned.[39]

The partiality is most pronounced where, on pages 7–8, the Director-General is asked to explain the benefits and costs of the NHI scheme. The heading "Beneficiaries" contains seven paragraphs of argument and explanation[40] of how all South Africans will be healthier and happier as a result of the NHI being implemented. This heading contains 629 words in total. This is to be contrasted with the heading "Cost bearers", which contains but one paragraph, listing the only cost-bearing sector of South Africa as being high net-worth persons because they will be paying more taxes. This heading contains but 74 words.

Furthermore, even the disadvantages accruing to this single cost-bearing sector are explained away, with the Director-General implying that the tax base which will absorb the cost is broad enough to do so. The reality is that the costs of the NHI on the whole of South Africa will be immense. Not only will ordinary South Africans lose their medical schemes, but with the State's

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38 BusinessTech. 2017, November 8. South Africa's tax revolt may have already begun. *BusinessTech*. Available at: https://businesstech.co.za/news/finance/209515/south-africas-tax-revolt-may-have-already-begun/.
See also: Cronje, F. 2019, November 3. *From Nelson Mandela to Wilkins Micawber – South Africa since the 1990s.* Daily Friend. Available at: https://dailyfriend.co.za/2019/11/03/from-nelson-mandela-to-wilkins-micawber-south-africa-since-the-1990s/.

39 See footnote 30 above.

40 No citations are provided, however, nor do the arguments provided penetrate through superficial puffery.

new, greater involvement in the private healthcare sector, that sector will contract, shed jobs and lead to disinvestment. The economic repercussions of the NHI are likely to be grave. Nevertheless, it is not appropriate for SEIA drafters to make excuses for or rise to the defence of an intervention, like the Director-General did in this case.

This display of partiality is repeated in the tables on pages 9–10. An entire page is dedicated to how all South Africans will benefit from the NHI, and scarcely half a page is dedicated to how, ostensibly, mostly only wealthy South Africans will be disadvantaged. Most perniciously, on page 10, where the assessment is simply asked to explain how private sector healthcare providers will bear costs, the Director-General instead *justifies* the proposed price controls (and thus costs on the private sector) by blaming the sector for the high costs of its services. Thus, it is not explained how costs would be borne, but rather blame is assigned to the disadvantaged group for government having to create the cost.

This analysis considers the phenomenon of unaffordable healthcare and the private sector elsewhere.

### *4.2.2 Laudation of the NHI*

On pages 7–8, the Director-General avers that the "benefits of NHI **are** multiple", that it will lead to "improved efficiency", "improved accountability", and "all South African [sic] **will benefit** from the implementation of NHI".[41] In other words, not even a quarter of the way through the assessment, the Director-General has already declared the intervention a resounding success.

The following pages are replete with similar puffery in favour of the NHI scheme, including such questionable claims like households having more disposable income because they will be forced to give up their medical schemes. Indeed, on page 8, it is said that "**only** households earning above R70000.00 may be required to pay NHI-specific taxes",[42] implying, uncritically, that such a state of affairs is just and equitable.

On page 33, the Director-General identifies the NHI Fund's proposed mechanisms and systems as "robust".

On page 36, the Director-General writes that a future government that favours privatisation is a "risk" to the NHI, and that it would "undermine a strong public health system". Implicitly, but obviously, the office of the Director-General has declared its preference for a State-led

41 My emphases.
42 My emphasis.

healthcare system, without having considered a private sector-driven alternative. This is a clear instance of ideological partiality in what is supposed to be an impartial study.

### *4.2.3 Hypocrisy*

On page 12, without realising the irony, it is said that costs in the private healthcare sector are driven up because of wages, salaries and other overhead costs (like marketing) that private medical schemes have to pay. This accounts for 10–15% of the total cost of a medical aid package. Despite this, there is no mention in the impact assessment of South Africa's public sector wage bill which, at the 2019 midterm budget statement, cost the taxpayer more than R500 billion.[43] In the 2017/18 financial year, government collected R1,22 trillion in tax revenue.[44] In other words, the public sector wage bill – salaries and wages, not counting other overheads – accounts for around 40% of the total cost of government. Furthermore, the assessment itself recommends on page 36 that the Department of Health should "[c]onduct massive [marketing] campaigns on NHI benefits".

The hypocrisy and irony would be amusing, were it not so expensive to the beleaguered taxpayer: The impact assessment lambastes the medical schemes sector for something government does with a far higher price-tag: Paying wages and salaries in exchange for little productivity, and marketing products with latent defects like the NHI. Whilst the office of the Director-General need not agree with this sentiment, it is improper and deceitful for it to have omitted any mention of how "non-health care costs" under a State-directed system will far outweigh that of the *status quo*, and illustrates its partiality in favour of government's proposals.

## 4.3 Imbalance

The partiality of the Director-General becomes obvious where it is admitted – perhaps unwittingly – that *all* the input by the critics of the NHI scheme were effectively ignored. The Director-General does not explain in any detail why this input was discounted, nor is there any real consideration of the merits of the critics' positions. In contradistinction, inputs by proponents of the NHI were considered and in some cases adopted into the scheme.

The assessment pertinently notes on page 13 that most government stakeholders support the NHI scheme. It notes the private sector had objections and claims that the Department of

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43 Mahlakoana, T. 2019, October 30. Mboweni: Public sector wage bill must be slashed. *Eyewitness News*. Available at: https://ewn.co.za/2019/10/30/mboweni-public-sector-wage-bill-must-be-slashed.

44 Stats SA. 2019. *A breakdown of the tax pie*. (2019). Available at: http://www.statssa.gov.za/?p=12238.

Health provided "reasons and explanations" for those disagreements. What follows is a clear manifestation of the imbalance of the impact assessment.

In the tables ranging from pages 14–24, the Director-General considers the stakeholders who support (fully or conditionally) or oppose the NHI scheme as well as their suggested changes to the scheme. The Department of Health then comments on whether, and how, the suggested changes were dealt with.

In each case where there is unconditional support for the NHI alongside a suggested amendment, the department indicates that those suggestions were considered and somehow adopted into the NHI scheme. On the other hand, where support was conditional or there was opposition, as well as suggested changes, the department dismisses those suggestions.

In some cases, these dismissals amount to begging the question – indicative of intellectual dishonesty – for instance, where it is said that amendments were not incorporated because they "are in direct contradiction to a single payer, strategic purchaser and are not based on principles that have been outlined" (page 14). In other words, the suggested amendments are rejected because they do not accept the current version of the NHI scheme – or government's ideological commitments – when the whole point of suggesting a change is because the current version is not acceptable. On page 19, where various private sector bodies indicated their conditional support of the scheme, subject to overhauling the NHI in favour of a voucher system for the poor, the Director-General notes that the suggestion was rejected because the "NHI is intended to establish a single pool of funds and risks and create an integrated unified health system based on solidarity". On page 24, similarly, when several private healthcare providers suggested an alternative scheme, it was rejected because that alternative "creates fragmentation and is not creating an environment of solidarity and risk pooling". These, again, beg the question, but also reject the very notion of an alternative to the NHI. Evidently, public participation that dissents from government's ideological framework is rejected offhand.

On page 23, various civil society organisations' objection that the NHI is unaffordable (discussed above) and must be abandoned is noted. The Director-General's response to this is simply, "NO, None [sic] of the proposals have been factored in". No reason is provided.

The impact assessment does not comment, critically or otherwise, on any of these phenomena. As previously noted, this is indicative of a flawed public consultation process. Government clearly entered into the process with a foregone conclusion – the NHI must be adopted as proposed (single payer, nationalised private sector, social solidarity) – without the possibility of being swayed otherwise. This defeats the purpose of consultation, meaning the entire process was a waste of the public's time, money and effort. The pretence of the process

was that the public would participate in the formulation of the policy, but this amounted to an intentional misrepresentation, and arguably *fraus legis*.

## 4.4 Intellectual dishonesty

Various examples of the intellectual dishonesty that permeates the SEIA are considered here. Because of the unjustifiable absence of many necessary citations and references, itself a material error in the assessment, most of what is discussed here pertains to weak arguments and crucial omissions.

It should be noted that these themes are found throughout the assessment, and therefore many of the headings below contain content that overlaps with that of other headings.

### *4.4.1 Missing the point*

Much of the assessment, indicative of the NHI scheme as a whole, misses the point regarding the problems in South Africa's healthcare system.

On page 11, the Director-General was supposed to describe problematic behaviour that would need to be changed for the NHI to succeed and then describe the mechanisms to achieve that change. The SEIA correctly identifies the public health system management as having a poor record of accountability and leadership and providing poor quality. There are hints at corruption, like the refusal by management to observe the Patients' Rights Charter. This is well and good. But the Director-General skirts around the issue when asked to identify the mechanisms through which the conduct would be changed, focusing mostly on the strengthening of existing State institutions. One does not put out a fire by pouring more fuel on it. State power is the root cause of the incompetence and inefficiency, particularly provisions in legislation and regulations that bestow upon bureaucrats unrestrained discretionary power and do not guide how those bureaucrats must conduct themselves.

Another obvious issue which the SEIA unwittingly identifies is the incentive deficit. In the private sector, non-performance and certainly criminal behaviour carry harsh consequences. Similarly, outstanding performance carries reward, which is why doctors from the public sector stream into the private sector in their free time as part of the RWOPS policy. In fact, far from simply ignoring the role of incentives, the SEIA recommends that the RWOPS policy be reviewed.

The least the SEIA could do in its recommendations to change poor public sector management was suggest an independent oversight body that is not answerable to any organ of State or politician, like a private council of medical practitioners or even the General Council of the Bar. But it does no such thing.

### *4.4.2 Inequitable distribution of resources*

Repeated mention is made of the so-called inequitable distribution of resources between the private and public healthcare sectors.

On page 2, it is said that "the health system is characterised by the maldistribution of human resources with a high proportion of health care professionals relative to the population located within the private sector". On page 3, this distribution is in part attributed to "poor implementation of policies such as [the] remunerated work outside of public service (RWOPS), where a significant proportion of full-time public service professionals perform work in the private sector". On page 5, "Skewed distribution of key health professionals between public and private sectors" is identified as a structural problem that the NHI scheme seeks to fix. On page 6, the assessment notes that 8,5% of GDP "is spent" on healthcare, of which 4,1% "is spent" on 84% of the population (i.e. in the public healthcare system) and 4,4% "is spent" on "only" 16% of the population (i.e. in the private healthcare sector). The assessment concludes on page 6 that "Health care benefits are not distributed in line with the need for health care services". This is because "the richest 20%" of South Africans are "receiving 36% of total benefits" whilst the poorest 20% "receive only 12.5%".

The unstated and seemingly unrecognised fact is that there is no "inequitable" or "fragmented" funding of healthcare, at least not in the way contemplated by the NHI scheme. By using terminology like "is spent" and linking that to the gross domestic product, the assessment implies that some central authority is directing where healthcare financing goes. In reality, users of private healthcare are paying for the service, using their own money – they are not "receiving" healthcare benefits by the grace of government. In other words, nobody is being disadvantaged, which is implied by the impact assessment. Person X purchasing healthcare for themselves does not better or worsen the lot of Person Y.

What government is in fact insinuating is that it seeks to seize resources from those who are currently paying for their own, private healthcare, and use that to provide healthcare services to those who rely chiefly on the public healthcare system. Indeed, the Department of Health acknowledges this in a later, more blatantly ideological and more poorly drafted "SEIA" on the NHI Fund, where it avers that:

> The current structure of the health financing system in South African health system limit [sic] the capacity for cross-subsidisation that would otherwise allow for the subsidisation of the poor by the rich, the sick by the healthy, and the elderly by the young.[45]

There is thus no inequity[46] – purchasing one's own healthcare is fair and reasonable. Government simply proposes to seize resources from productive citizens to make up for its own failures in delivering quality public healthcare to the poor.

On page 12 it is averred that there is "over-servicing" in the private healthcare sector to justify higher prices. This is due to the "fee-for-service environment". The latent error underlying this statement is a notion of objective value. The office of the Director-General believes, perhaps unbeknownst, that it has identified a metric by which the health needs of individuals can be objectively identified – indicative of the central planning mentality that underlies the NHI scheme as a whole. To the Director-General's office, even if someone has paid for a service, that service could be classified as an "over-service", in the same way government might desire the public to only indulge in eating 200 g rather than 500 g steaks at restaurants.

The reality is that consumers do – and have the right to – make free choices based on their own subjective perception of their healthcare needs. The impact assessment engages with this in a superficial and politically partial manner, by endorsing the price control mechanism put forward in the NHI scheme. This is done again on page 33. The detrimental impact of price controls – usually shortages – are mentioned nowhere in the assessment.

On the contrary, the Director-General goes to lengths to justify further monopolisation in the healthcare market. They argue, for instance, that there is an "over-supply of hospitals" *and* "market concentration" *at the same time*. In other words, greater competition, to the Director-General, means higher concentration and therefore higher prices; whereas basic economic theory indicates the opposite: Greater competition leads to lower prices. The impact assessment, therefore, is engaged in peddling a demonstrably false narrative to the South African public about how the economy functions, and suggesting solutions they claim will drive prices down but which will either drive prices up and/or lead to shortages.

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45 Director-General: Health. 2017. *Socio-Economic Impact Assessment System (SEIAS): Initial impact assessment: National Health Insurance Fund*. Department of Planning, Monitoring, and Evaluation, p. 3.

46 One must be mindful of definitions in this context. "Inequity" refers to something that is unfair or unjust. This is not the same meaning as "inequality", which is a valueless term that refers to imbalance or 'not the same'. There is nothing inherently unfair or outrageous about the mere fact that two or more things, people, or phenomena are 'not the same'. The NHI scheme in this context refers to inequity, not inequality, which might be a further indication that government is attempting to shore up outrage about a harmless *inequality* by using the rhetoric of unjust *inequity*.

### *4.4.3 Remunerated work outside the public service*

The Remunerated Work Outside the Public Service (RWOPS) policy is repeatedly targeted throughout the assessment as part of the reason for poor performance in the public healthcare system. This policy allows public healthcare system professionals to work, for profit, in the private healthcare sector. Why these professionals decide to do this clearly has to do with incentives. Greater incentives usually lead to better quality work.

On page 37, the Director-General complains of the low levels of participation by doctors and the private sector in the NHI. He does not ask why this is the case – the incentive deficit that exists between the public and private sectors – but instead proposes, implicitly, to do away with the RWOPS.

The RWOPS is not the problem, however. It is a pressure valve that allows discontented State doctors to do good work in the private sector. Removing the pressure valve might lead to a total unwillingness of medical professionals to work in the public sector.

### *4.4.4 Right to access to healthcare*

On page 5, the assessment refers to the "excessive burden on the public health system" that the NHI seeks to address. What is not mentioned by the Director-General is that this burden, which the public health system has assumed, was assumed voluntarily by government.

There is a pervasive notion that the Constitution obligates government to play a central role in healthcare. Indeed, this sentiment is by no means limited to the health department. The Human Rights Commission, too, has concluded that, "In terms of [section 27 of the Constitution], the South African government has an obligation to provide health care services for everyone", particularly the poor who are reliant on such services.[47]

In reality, section 27(1)(a) provides that "Everyone has the right **to have access** to health care services",[48] and section 27(2) provides that the State's capacity may limit or delay the realisation of this right. There is a linguistic and legal difference between having the "right to" healthcare and having the "right to have access to" healthcare, particularly in light of the limitation in section 27(2).

However one chooses to interpret this provision, it is evident that the Constitution does not provide explicitly, nor does it imply, that government must be the steward of the entire healthcare system and take a leading role in all things health-related, which is what the NHI

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47 Kollapen, J et al. "Public Inquiry: Access to health care services". (2007). Human Rights Commission, p. 18. Available at: https://www.sahrc.org.za/home/21/files/Health%20Report.pdf.

48 My emphasis.

scheme attempts to realise. The limitation in section 27(2) strongly implies that the greater capacity and competence the State displays, the greater its role in the healthcare system could be, and *vice versa*. It is trite that the South African government has displayed a remarkable lack of capacity and competence in this regard, leading one to conclude that it cannot act as a steward and that it certainly has no business sponsoring an intervention like the NHI.

It does not follow, furthermore, that whatever avenue government chooses to give effect to this right is inherently constitutional. Indeed, section 27(1)(a)'s wording clearly implies that this provision protects the *ability to access* healthcare, and if government's intervention hinders such access, it would be unconstitutional. The Constitutional Court, in relation to the right to housing, made this clear in the case of *Government of the Republic of South Africa v Grootboom*:

> Although the subsection does not expressly say so, there is, at the very least, a negative obligation placed upon the state and all other entities and persons to desist from preventing or impairing the right of access to adequate housing.[49]

As will be discussed below, the NHI scheme evidently limits such access by depriving South Africans of their medical scheme subscriptions.

In other words, not only has the Director-General, alongside the Department of Health and the Human Rights Commission, uncritically accepted a single, flawed interpretation of section 27, but they have also accepted conduct that undoes the very right they ostensibly seek to champion. Such a potential impact – the extinguishing of a right – ought to be in the forefront of an impact assessor's mind, but such was not the case in this assessment.

### *4.4.5 Assumption of effectiveness*

Another unjustified thread running throughout the impact assessment is the assumption of effectiveness. In other words, despite some recognition of corruption and incompetence, the Director-General's office assumes fundamentally, quite detached from reality, that an effective and competent government presides over South Africa, in particular over its public healthcare system.

On page 3 it is said that a single monopsony purchaser would engage in "strategic purchasing of health care services" and that this would "improve the efficiency and performance of the health system…" On page 11, where the Director-General is expected to list ways in which change in government's corrupt and inefficient behaviour would be enforced, there is merely talk of strengthening oversight mechanisms and other policy changes. There is no mention of

[49] *Government of the Republic of South Africa and Others v Grootboom and Others* 2001 (1) SA 46 (CC) at para 34.

changing incentives – the fundamental reason for lacklustre public service performance – nor of changes to enabling provisions in legislation and regulations, which are the chief enablers of corruption and mismanagement. In fact, the Director-General recommends that the RWOPS policy be reviewed – something that will disincentivise public sector healthcare work even more. The Director-General also regards merging the private sector into the public system as a solution to the ineffective coordination and stewardship of the Department of Health. In other words, by giving government more control over the private sector, it will be better placed to solve its own internal inefficiencies. This line of reasoning, it need not be explained, is ludicrous.

It is claimed on page 8 that there are economic impact assessments that indicate the positive impacts the NHI could have on health in South Africa, but these studies are not cited. These ostensible advantageous outcomes, the assessment claims, will also increase the overall happiness of South Africans. It is ironic, given that the available evidence points to the contrary position: There is widespread discontent with the public healthcare system, and extending this system to incorporate the existing private healthcare sector – as the NHI scheme proposes to do – can only lead to that discontent being exacerbated.

At no point is there a frank recognition of the indisputable fact that the South African government is wholly incapable of administering the NHI scheme, and certainly incapable of providing "stewardship", as required by section 31 of the NHI Bill, to both the public *and private* healthcare sectors.

### *4.4.6 Assumption that the market does not exist*

Throughout the assessment, there is a latent assumption that South Africans either cannot or do not make decisions based on their own self-interest and preferences, and that government must make these decisions for them. See, for instance, page 5, where "Poor clinical governance in the private sector" is identified as a structural problem that the NHI scheme seeks to address. To government, it takes a legislative or regulative intervention to put right inefficiency or incompetence in private companies. In reality, consumers take their business elsewhere.

On page 12, further, the Director-General claims that one of the problems in need of fixing in the private sector is that there exist no "mechanisms for measuring quality and outcomes". Here the assumption that the market does not exist is overt rather than latent.

The market, with supply and demand and the price mechanism, is practically wholly aimed at measuring quality and outcomes. This is why, *ceteris paribus*, restaurants that serve bad food close down, and why restaurants that serve good food grow and succeed. No government regulator closes them down, but they lose business as consumers withhold their money and

flock to superior competitors. For the Director-General to assert that in the absence of some government office measuring quality, South Africans will simply be the victims of shoddy healthcare services in the private sector, is a false, and arguably intentionally deceitful, claim to put in the public domain.

On page 37, the Director-General avers that there is "excess capacity" in the private health sector. This betrays a fundamental misunderstanding of economics. Shortages occur when there is high demand and low supply. Surpluses, which the Director-General is referring to in this case, occur when the demand is low, and the supply is high. Alternatively, shortages also occur when prices are too low, allowing the high demand to use up the supply. Similarly, surpluses occur when prices are too high, making the supply inaccessible. This does not ordinarily happen in markets, unless there are price controls. In the market, if there are truly surpluses, prices would decrease. Evidently, then, there is no surplus, and the impact assessment contains no citation for this absurd claim. The price controls proposed by the Department of Health, however, will certainly *itself* cause such market distortions – principally shortages, given the high demand for healthcare.

On pages 40–41, the Director-General identifies the poor quality of care in the South African healthcare system. It is trite that such poor quality emanates mostly, but not exclusively, from the public system. The SEIA nonetheless considers both the private and public sectors to have problematic quality of care and recommends "standards and norms" that both sectors must adhere to. These standards include the reduction of waiting times. What is ignored by the Director-General is that the NHI scheme itself will increase waiting times and reduce quality for everyone. This is because the proposed price controls will cause a price distortion – patients will flock to facilities for "free" healthcare, causing a shortage. Today, one can find refuge in the private healthcare sector, but the NHI proposes to do away with that.

Similarly, on page 42, the Director-General's office problematises "unnecessary" visits to healthcare providers, or providers servicing patients "unnecessarily". As a potential solution to this "problem", the Director-General suggests the introduction of an "NHI TV channel educate people on appropriate use of NHI benefits". In a free healthcare market – an unconsidered alternative in the assessment – this is not a problem, because users who use services "unnecessarily" suffer the consequences themselves by having to pay for nothing. But as the Director-General here notes – unwittingly, but correctly – this is only a problem when taxpayers' money is used. The NHI creates a healthcare commons, and the tragedy of the commons (overuse of a common resource because it is "free" at the point of use) will apply. As discussed above, it will lead to shortages in the supply of healthcare. Again, the Director-General, in addition to suggesting making healthcare spending even more expensive with the

introduction of a television channel, failed to consider the appropriate alternatives that would solve their apparent "problem".

### *4.4.7 Ignoring the fact that regulation leads to expensive medical schemes*

On page 6, the assessment notes that South Africa's private medical schemes are some of the most expensive in the world.

At no point in the impact assessment does the Director-General consider the fact that private healthcare in South Africa is as expensive as it is as a result of regulation. It is trite in economics that higher input costs and artificial restrictions on supply will cause end-user prices to increase. It is no surprise, then, that healthcare in South Africa is this expensive, in light of legislation like the National Health Act.[50] Section 36 of the National Health Act *inter alia* prohibits the establishment of health agencies, increasing the number of beds in a hospital, acquiring new technology and providing health services, without possessing a "certificate of need". The Department of Health may not issue or renew a certificate of need without having complied with an ideological formula set out in the Act. Among other things, the promotion of "an equitable distribution and rationalisation of health services", the promotion of "an appropriate mix of public and private health services", the demographics of a community, guarding against "perverse" (likely profit-related) incentives, and the for-profit status of the applicant, must be considered before such a certificate is issued. These factors have little to do with the provision of quality healthcare, and inherently drive up costs.

The prescribed minimum benefits that government forces private medical schemes to provide to clients of necessity also artificially raises prices. Without this burdensome intervention, there would be more medical aid options available for clients to choose from in lower price ranges.

The impact assessment makes no mention of any of this. It has failed to paint a comprehensive picture of the mischief the NHI scheme wishes to solve. It has, instead, painted a total misrepresentation of reality, shifting any blame away from policy failures to private sector greed and public sector corruption.

### *4.4.8 Nationalisation of private healthcare*

At various junctures throughout the SEIA, there is explicit mention of the NHI scheme's goal of eliminating, at least, parts of the private healthcare sector. On page 2, it is said that the "NHI is aimed at transforming the fragmented two-tiered health system, the public and private, into a unified health system…". On page 10, the Director-General writes that "There will be consolidation in the sector and the number of schemes will reduce". In other words, the NHI

50 National Health Act, 2003 (Act 61 of 2003).

is enabling and encouraging monopolisation and concentration in the sector. On pages 34-35, on the other hand, the "big health industry players" are accused of collusion and "mobilising resources". This contradiction between the desired ends and the mischief the NHI hopes to cure is not noted in the SEIA.

On page 12, it is said that government will administer the NHI, and as a result the private sector brokers and administrators will no longer be required. On page 36, it is made explicit that participation in the NHI Fund will be compulsory, and that the public will have no opt-out option. The assessment does not pause to consider this blatant infringement on section 27(1)(a) and section 18 (freedom of association) of the Constitution. It is further made clear that private medical schemes would only be allowed to provide "complementary cover", a further infringement of freedom of choice.

In the later SEIA on the NHI Fund, the "continued existence of a separate public and private sectors [sic]" is also problematised, to the extent of identifying the fact that there is both a public and private healthcare sector as a "main cause" of the high disease burden government seeks to address.[51]

On page 8, the Director-General claims that healthcare providers in the private sector will benefit from the NHI because "the patient base will be expanded whilst there will be more certainty on their potential income". This is akin to saying the policy of expropriation without compensation "benefits" owners of agricultural land because they will now have certainty about their significantly reduced potential income and asset value. In the context of the NHI claiming to phase out the private healthcare sector – or "defragmenting" the "two streams" of healthcare into one – it is perplexing how it could be claimed that the private sector will benefit in any way, shape or form.

At no point does the SEIA ask whether the nationalisation of private healthcare is necessary or appropriate. The effective nationalisation of billions of rands worth of private property – not merely the private property of the medical aid owners, but also the financial interests that millions of ordinary South Africans have in those aids – is treated as an aside that is on its face, without the necessity of further explanation or evidence, justified.

The constitutional implications of the nationalisation of private healthcare are similarly left unconsidered. There is mention of the "risk" of constitutional challenges to the NHI on page 36, but the assessment does not engage with the viable constitutional arguments against the scheme. Instead, the way they deal with this "risk" is to say that an:

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51 Director-General: Health (footnote 45 above), p. 3.

> […] NHI act [sic] that incorporates all current legislation in compliance with the Constitution [must be promulgated]. This provides the legal framework to operate with the constitution.

In other words, to the Director-General, enacting legislation that contains elements from previous legislation is a guarantee of constitutionality. This is, of course, incorrect. The fact that the NHI creates a new regime that eliminates a substantial part of the private market in and of itself means that the previous regime, which does not do so, provides no justification. It is unfortunate that the Director-General's office hides behind such a shallow argument when, properly, it should have discussed, in detail, the implications the NHI will have for section 18 (the right to freedom of association), section 25 (the right to property), and section 27 (the right to have access to healthcare).

### *4.4.9 Achieving "national priorities"*

On pages 46–47 the Director-General is tasked with summarising "the impact of the proposal [NHI] on the **main national priorities**".[52] The Director-General then proceeds to list five so-called national priorities: Social cohesion, security (safety, financial, food, energy "and etc."), economic growth, economic inclusion (job creation and equality), and environmental sustainability.

At best, only two of these five listed priorities could be classified as national priorities, that is, security and environmental sustainability. The other three "priorities" are not national priorities, particularly if one considers the Constitution as the charter of South Africa's national priorities. Neither social cohesion nor economic growth or inclusion are constitutional imperatives, and certainly not obligations government is tasked with achieving.

What is most telling, however, are the actual national priorities that the impact assessment omits. Freedom is a national priority emphasised in sections 1(a), 7(1), 36(1), 39(1)(a) of the Constitution and the Bill of Rights generally, but the impact of the NHI on freedom of choice and freedom to access healthcare is nowhere considered in the assessment, and certainly not on these pages that have regard to South Africa's national priorities. Security of property is another national priority that is not mentioned.

### *4.4.10 Poor draftsmanship*

There is a general thread of poor draftsmanship that is evident throughout the SEIA. See examples above indicated with "[sic]".

A glaring example is where the Director-General identifies the problem of the "high premiums" of medical schemes being "unaffordable for members" of those schemes on page 12. This is

[52] My emphasis.

a contradiction in terms. By its very nature, a member of a scheme can afford the premium of that scheme. If they cannot, they would not and cannot be members

Finally, at the end of the impact assessment, on page 48, when asked to identify additional areas of research that would improve the understanding of the costs and benefits of the NHI, the Director-General writes "N/A at the moment", despite this being the final impact assessment. There are no further opportunities for making such research known to the public, at least not in the impact assessment paradigm. The Director-General is also *thrice* designated as "Director-**Genral**: Health".

The impact assessment was not conducted with the necessary level of care and respect deserving of a study aimed at facilitating and enabling public participation in policymaking.

## 5. CONCLUSION

This analysis set out the public policy imperatives and characteristics of properly conducted socio-economic impact assessments and measured the Department of Health's impact assessment on the National Health Insurance White Paper against those standards.

The impact assessment does not contain all the information necessary for the public to conclude that the benefits of National Health Insurance outweigh its costs. In fact, the assessment, through a lack of neutrality, balance and intellectual honesty, weaves an intricate web of deceit to convince the public that government has covered all its bases and considered all the perspectives and alternatives to National Health Insurance. It is replete with the puffery of good intentions and has little to no detail on either the foreseen and, more importantly, potential unforeseen, disadvantages that will follow from its implementation.

This deceit and cajoling of the public have not been limited to the impact assessment. Siviwe Gwarube MP claims that Parliament is engaging in similar behaviour. At its hearings on the National Health Insurance Bill, Parliament distributed pro-NHI leaflets to participants. Thus, rather than enabling the public to participate in the policy-making process on the basis of objective facts, Parliament wishes only for the process to further strengthen its foregone conclusions. The ruling party had long ago decided that NHI was going to become a reality, and constitutional institutions like public participation and impact assessments would not be allowed to stand in the way.[53]

It is evident that the impact assessment fails on every measure and peddles a misrepresentation of the true nature and consequences of the National Health Insurance

[53] Gwarube, S. 2019. *Parliament misleads the public by politicizing NHI public hearings*. Democratic Alliance. https://www.da.org.za/2019/10/parliament-misleads-the-public-by-politicising-nhi-public-hearings.

scheme. The National Health Insurance Bill, based on the White Paper, is therefore grounded in faulty evidence and reasoning, and must be reconsidered. Should government wish to persist in its campaign for attaining a public health insurance scheme for South Africa, it must first commission a proper impact study taking into consideration all the relevant factors (affordability to the public fiscus chief among them), viewpoints (including and especially those of opponents), and alternatives (private sector-led examples like the voucher system being foremost among them). The current NHI scheme ought to be set aside.