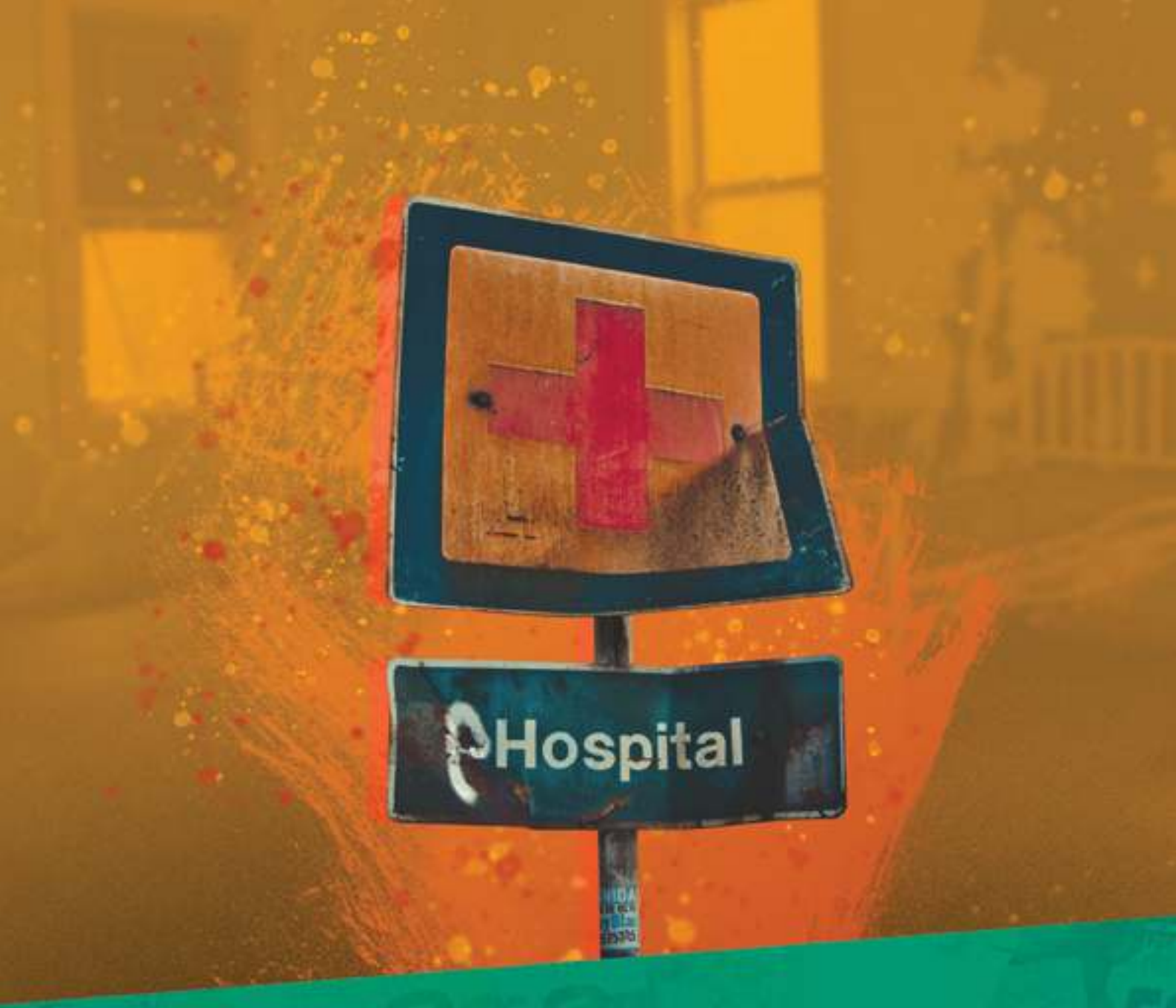

NHI:

AN UNAFFORDABLE HEALTH CARE DISASTER

AfriForum

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INTRODUCTION

At the outset we wish to convey our dismay that despite over a decade having passed since the ruling African National Congress first mooted the idea of National Health Insurance (NHI) and considering the numerous policy documents published and debated, South Africans are no closer to understanding any of the critical details of the proposed NHI scheme, such as how much the scheme will cost, where the money to pay for it will come from and where the country will obtain the additional personnel (both medical and bureaucratic) to staff the ambitious scheme.

Given the conspicuous absence of these and other critical details we can only assume that the government's proposed National Health Insurance scheme is a politically motivated event that will not materially improve the health outcomes of the poorest and most vulnerable members of society. Indeed, we are reminded about the quote by Paul Starr, who states,

> *Whoever provides medical care or pays the costs of illness stands to gain the gratitude and good will of the sick and their families. The prospect of these good-will returns to the investment in health care creates a powerful motive for governments and other institutions to intervene in the economics of medicine. Political leaders since Bismarck seeking to strengthen the state or to advance their own or their party's interests have used insurance against the costs of sickness as a means of turning benevolence to power.*[1]

In this study we estimate that NHI will cost taxpayers R446,8 billion in 2018 prices. But when one considers that the total revenue from personal income tax collections – South Africa's main source of tax revenue and the main vehicle for financing NHI – amounted to only R425 billion in 2017, we get some idea of the futility of the government's ambitious scheme.

The country not only lacks the financial resources to fund NHI, but the quality of care in the public sector is so abysmal that few facilities would qualify to provide services under NHI. According an Office of Health Standards Compliance (OHSC) report, only five of the 696 hospitals and clinics it inspected in 2016-17 complied with the Department of Health's norms and standards to achieve an 80% "pass mark".[2] In this same report it shows that 26% of public facilities inspected were critically non-compliant with a further 36% being non-compliant.

Considering the high levels of poverty and unemployment, the small tax base and the poor performance of the public health sector, it is difficult to envision how a government-funded system that promises "free healthcare for all" is appropriate for South Africa. The NHI scheme is based on a government administered, centrally controlled, single-payer model. Under NHI, whether directly or indirectly, government will control the availability, financing and delivery of healthcare for all.

The consequences of the government adopting its proposed NHI policy are entirely predictable. It would reduce the quantity and quality of South African healthcare provision, drive more healthcare professionals out of the country, create a bureaucracy incapable of efficiently handling the huge volume of claims and impose an unnecessary and intolerable burden on both government and taxpayers. The government's NHI policy concentrates power in the hands of government and requires it to act as both player and referee, leaving no room for the private sector.

Our concerns are succinctly summed up by Professors Servaas van den Berg and Heather McLeod who stated in 2009, "Our fear is that the proposed NHI will fail to meet the expectations of the poor, will leave medical scheme members (including the working poor) worse off, will be massively expensive or even completely fiscally unaffordable, and will require far more doctors and nurses than are available. The danger is that it could well become a highly costly failure that will further increase frustration with service delivery".[3]

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1 Starr, P. 1982. *The social transformation of American medicine: The rise of a sovereign profession and the making af a vast industry.* New York: Basic Books. p. 235.

2 Kahn, T. 2018. Only five out of 696 hospitals, clinics got a 'pass mark' in SA. *TimesLive.* Available at https://www.timeslive.co.za/news/south-africa/2018-06-06-only-five-out-of-696-hospitals-clinics-got-a-pass-mark-in-sa/. Accessed on 15 October 2018.

3 Van der Berg, S. & McLeod, H. 2009 South Africa: Crude NHI Plan Threatens to Make a Bad Situation Worse. Business Day. Available at https://allafrica.com/stories/200909040441.html. Accessed on 15 October 2018.

LESSONS FROM THE NHS

It would be no exaggeration to say that the National Health Service (NHS) in Britain is often regarded as the benchmark for countries wanting to establish their own national health service. Our Minister of Health has personally proffered the supposed success of the NHS to critics in his justifications when questioned about NHI. However, British euphoria created around the NHS often involves substantial technical inaccuracies on its clinical achievements and patriotic hysteria that any alternative proposal to the NHS means a move to a USA style system.

The US health market is a unique outlier in the world, thus making any comparative reference to it superfluous. Nonetheless, in a rhetorical sense it is an easy target to reference against because of its multiple and costly failures. This latter point is relevant because often protagonists of healthcare systems, and the SA government is in precisely this trap, only have two varieties of healthcare systems in mind – either entirely nationalised or entirely private. Clearly the SA government strongly favours the former.

The truth is that the vast majority of healthcare systems around the world that achieve universal coverage are a healthy blend of competing private and public providers and funders. Furthermore, the funding mechanisms are a combination of out-of-pocket spend, privately pre-funded contributions and tax-funded healthcare.

It is also not a pre-condition to have free access or for the state to procure only from state-owned healthcare entities. If the state and/or private funders can procure from either public and/or private providers in competition with each other, inevitably, these competitive market forces would bring about cost efficiencies and outcome improvements that no monopolised national health system can compete with.

Approximately 75% of Brazil's citizens are covered by the public sector, with the remaining 25% covered by the private sector. An estimated 56% of funding comes from private pre-paid or out-of-pocket expenditure. The Netherlands achieves universal health coverage, but its government owns neither a single health facility nor health insurer. In Germany 60% of hospital beds are privately owned.

The way in which the two sectors, private and public, are blended together, working collaboratively, determines the relative success or failure of an overarching national objective. Nonetheless, the single principal contributing factor determining universal access to healthcare remains per capita income of a country. Therefore, government's focus on growth and their reduced expenditure remain key cornerstones of attaining universal health coverage.

NATIONAL HEALTH SERVICE REFORMS

A direct comparison between SA and the UK would not be feasible. The countries are vastly different in demography, wealth, tax base, industry, disease burden – virtually every metric one could imagine. However, the UK does have a tax-funded national health structure similar to what the SA government is now proposing within the NHI bill. It is therefore useful to have a look at certain aspects of the NHS to see where it has failed and where it has succeeded over the years.

Total healthcare spend in the UK is 8,5% of gross domestic product (GDP), whereas other OECD countries typically spend around 11%. Therefore, the NHS is often regarded as being more cost effective and efficient when compared to similar systems in other countries. However, when gauging the NHS on health outcomes, it falls short comparatively with these same countries,[4] scoring poorly across a range of clinical outcomes. This can be typically ascribed to the fact that the NHS is primarily a 'complementary' system – it only allows participants to purchase parallel, usually private, services that are not part of the statutory services delivered by the NHS.

Supplementary systems on the other hand allow the parallel private purchase of all services, including any statutory services (effectively an 'opt-out' system). In complementary systems, the out-of-pocket or private spend by citizens is automatically constrained since they are compelled to make use of the monopolised statutory system and cannot use alternative means to fund their healthcare. This monopoly is a key issue. But more on that later.

As was the case with the previous NHI bill, there remains some uncertainty as to whether NHI will be a complementary or supplementary system. The NHI bill released on 8 August 2019 states in clause 33 that medical schemes will only be permitted to offer services not covered under NHI services (i.e. a complementary system). However, clause 8 of the bill allows for users to opt out of the referral pathways stipulated by NHI and then claim these services from their "voluntary medical insurance scheme".

Public commentary made by the Minister of Health and several senior health officials have insisted that the system is complementary.

Given SA's very narrow tax base and limited supply of providers, a supplementary system makes more sense since wealthier citizens will happily contribute towards private care and not rely on state funded healthcare, thereby alleviating limited state resources.

In any event, government would do well to revamp the private sector regulatory framework[5] to enable the private

[4] Niemietz, K. 2016. *Universal healthcare without the NHS — Towards a patient-centred health system.* IEA. Available at https://iea.org.uk/publications/universal-healthcare-without-the-nhs/. Accessed on 15 October 2018.

[5] The Medical Schemes Amendment Bill will not be discussed here other than to say it should be appropriately revised to expand cover to more citizens willing to purchase supplementary cover.

sector to expand cover to more citizens, as in Brazil. There is a multitude of examples where governments have encountered funding problems in nationalised health systems, leaving them two choices – cut back on services or relax regulatory control and allow citizens to purchase their own healthcare (or at least a portion thereof) if they can do so.

Governments that exercise the latter choice, create a more progressive realisation of Universal Health Coverage (UHC), since privately pre-funded care alleviates pressure on the State's limited resources, effectively raising the level of care for all citizens. It may not be equitable but nonetheless, on average, all citizens will enjoy superior levels of healthcare as a result.

The UK system, whilst still primarily tax funded, has undergone substantial and positive reform over the past three decades. More needs to be achieved in this regard as far as the NHS is concerned but for our purposes now, we can garner substantial learnings from examining these reforms.

NATIONAL HEALTH SERVICE REFORMS OF THE EARLY 1990S

Prior to the 1990s, the NHS was practically a single state-owned entity. To bring about typical market forces of a free market economy, a new reform in the early 1990's introduced a separation of the funding and provision of care. Funders were split up into the District Health Authorities (DHA) and hospitals separated into their own legal entities called NHS Trusts (Trusts). DHAs had to actively seek out contracts with the Trusts and, conversely, Trusts had to compete for services.

It was not a resounding success by normal market comparison, but this reform did bring about positive changes necessary to eradicate the inefficiencies that existed within the NHS because of its original monopoly structure. The two broad monopoly components were in funding and delivery and after this reform, both the DHAs and the Trusts had to focus more heavily on consumer choices and patient outcomes. Research in 2007 revealed that:

> *The general criticism of centralised control is that the "central planners" will lack knowledge of local conditions, especially the type of knowledge that cannot easily be expressed in numbers or even words ('tacit knowledge'). The British experience with centralised performance management of the health service amply illustrates the validity of this criticism.*[6]

Central control, typical of these sorts of monopolised health systems, can be likened to the central control theories of Marx and Lenin that were implemented by the Soviet Union ('Gosplan' being the USSR's central control planning unit). Gosplan tried to control everything from supply to demand, to quality, type of service, etc. The failure of Gosplan and similar centrist systems, are documented broadly enough to make duplicative criticisms here needless. What does remain a mystery is why any modern-day government would want to replicate such a universally failed system.

The NHI proposes creating a national, single-payer health system for SA that will dictate service levels, price and extent of care. This is precisely what should be avoided rather than duplicated. The second major reform within the NHS is highly informative on this point.

NHS REFORMS OF 2002

From around 2002, another reform was phased into the NHS – patient choice. This was brought in gradually over time and at various levels of care, but the affect was obvious and substantial. Previously, limited choice of providers for NHS patients meant that providers only competed between themselves for contracts with the local DHA.

Now providers had to compete for patients and not so much for contracts, and after funding rules and reimbursement mechanisms were changed so that money followed patients, the Trusts became focused on attracting patients. Waiting times reduced, patient satisfaction surveys became all important metrics and, critically, clinical outcomes also improved.[7]

Provider structures fundamentally altered to become less centralised, with more integrated care units being established around patient needs and achieving better outcomes. Since DHAs could now cover any patient at any Trust, even they had to improve their services in order to retain patients.

A note on NHS Measurement

Another critical aspect of the NHS for SA to bear in mind is that of creating a quality measure of clinical outcomes. Tied together with providers competing for patients, it becomes an essential tool in maintaining the competition between providers and giving patients the ability to choose providers based on their outcomes (as opposed to where they are regionally contracted within the NHS as it was prior to the reforms outlined herein).

[6] Hauck, K. & Street, A. 2007. *Do Targets Matter? A comparison of English and Welsh national health priorities.* Available at https://www.york.ac.uk/che/pdf/streettargets.pdf. Accessed on 15 October 2018. (Wales introduced the reforms substantially later than England.)

[7] Niemietz, K. 2016. *Universal healthcare without the NHS – Towards a patient-centred health system.* IEA. Available at https://iea.org.uk/publications/universal-healthcare-without-the-nhs/. Accessed on 15 October 2018.

SUMMARY OF NATIONAL HEALTH SERVICE

In summary, although the NHS is often is often touted as being the benchmark for nationally-owned, single-payer health systems, in practice it is no longer a singlepayer system. While the funding is derived primarily from taxes (single source), it can be regarded as being a multi-payer and multi-provider system, with the DHAs and Trusts having to compete for patients.

The following simple but powerful free-market principles were achieved:

- Member choice of insurer meant that premiums (i.e. funding) followed the funder.
- Patient choice of provider meant that reimbursement for services (i.e. payments) followed the provider.

The only way this could be achieved was by not having a single-payer system and by ensuring that providers compete for patients based on clinical outcomes. It is by no means a totally free market system since any failed DHA or even Trust will be bailed out by the government. It also still lags its European counterparts in terms of outcomes. Nonetheless, after the substantial change from a single-payer system, the NHS has shown much more improvement in outcomes than its peers over the past three decades.

These changes were effectively foisted upon the British government, compelled to bring about the necessary changes to the way the NHS was structured to contain costs, improve outcomes and essentially meet the needs of British citizens.

SA is now embarking on the road of a single-payer system, much like the NHS was prior to the 1990s. Experience has shown that a system like the NHS is inherently weak and suffers from the typical problems that all monopolies suffer from – growing costs, declining quality and an unmanageable bureaucracy.

It would be prudent for SA to consider leveraging off the substantial skills that exist with the private sector to deploy a multi-payer system with funders competing for members, similar to what the NHS has now implemented. Similarly, a structure where providers compete for patients based on quality outcomes and patient satisfaction would be more economical and clinically effective than the deployment of a massive army of inspectors through the OHSC.

EVALUATING THE POTENTIAL COST OF NHI

To coin a colloquial saying, the 'elephant in the room' is the cost of NHI.

The cost of NHI is, at this point in time, not accurately quantifiable. This is simply because the proposals in the NHI bill are devoid of details on the so-called compulsory package of benefits, provider reimbursement levels or whether or not citizens with sufficient means will be allowed to cover themselves privately through medical schemes (i.e. whether NHI is a supplementary or complementary system). All these factors could have a substantial impact on NHI costs.

Considering the magnitude of the changes proposed by the NHI bill, it is our view that it is grossly negligent to avoid an accurate understanding on costs whilst still proceeding with its implementation.

Quoted in the NHI white paper below, the Department of Health (DoH) suggests that the World Health Organisation (WHO) is declaring cost as unimportant:

> *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 implementing reforms towards achieving UHC.*

What the WHO has in fact said on this matter is:

> *Ultimately, what will UHC cost depends critically on how it is designed and implemented. In that sense, looking at costing scenarios and assumptions may be valuable for raising some core policy issues. (Own emphasis.)*

Further to that, the DoH is quoted in the white paper:

> *NHI represents a substantial policy shift that will necessitate a massive reorganisation of the current health care system. (Own emphasis.)*

The DoH is thus disingenuous by suggesting that the WHO is dismissive of costs in achieving UHC. Quite the opposite, the WHO states that it is vital in assessing core policy changes and there can be no doubt in anyone's mind that the NHI bill represents a substantial policy change. We strongly believe that it is incumbent on government to undertake a comprehensive costing analysis of what cost NHI will impose upon taxpayers before the NHI bill is evaluated by parliament.

We can, however, at this stage make a few assumptions around which to build an understanding of what the cost could amount to. It is important to note that the costing methodology is purely a mathematical extrapolation of costs in the private sector[8] with certain appropriate cost

[8] Private sector healthcare costs are the only costs readily available in detailed form from which to analyse costs.

adjustments to get to a possible NHI cost. It ignores other factors that would undoubtedly have an impact on the viability of the NHI proposals, such as provider shortages, differing reimbursement models and disease burden differences between the private and public sector users.

COSTING METHODOLOGY — BENEFITS

The Council for Medical Schemes (CMS) has over the past year or so undertaken a review of the benefits contained within prescribed minimum benefits (PMB). PMB's are a statutory package that all 80 medical schemes in SA are required to cover (excluding several with exemptions). More importantly, it has on several occasions mooted this revision as necessary to build towards implementation of the NHI.

The current PMB's are primarily made up of conditions requiring specialist inpatient services, oncology-related out-patient services and ongoing (chronic) medicinal treatment. Since this package is made up of almost entirely curative services, the PMB revision is seeking to add to an array of preventative basic primary care services to avoid more expensive future curative treatments.

Given the public statements by the CMS that this revision is required as a build up to the implementation of NHI, it is reasonable to assume that the comprehensive package within the NHI will resemble the existing PMB package plus a basic level primary care package. The basic primary care package is likely to be inclusive of GP consultations, acute medicines and basic diagnostic services. From this we can gain some understanding of what the costs of providing such a package would be.

According to the latest CMS Annual Report (2017/18), the average treatment cost in 2017 of the current PMB package across the medical scheme industry equated to R746 per beneficiary per month (pbpm). The medical schemes industry is, however, rather anomalous in terms of socially oriented regulatory frameworks in that it maintains open enrolment and community rating without the risk balancing factor of mandatory membership. This enables widespread anti-selection which has the effect of raising treatment cost significantly since it is generally those of poorer health that partake within the industry.

Since the NHI proposal is that membership will be mandatory for all citizens and as such anti-selection will not exist, it is realistic to remove that factor in our calculations. An evaluation undertaken by local healthcare actuary Barry Childs in 2015 showed that if mandatory cover were in place, treatment costs within the medical schemes industry would be approximately 30% lower than they are now.

The average cost of R746 pbpm is from the CMS's 2017 report. Therefore, to obtain a current cost for 2019, we would need to inflate that cost forward by two years. Medical inflation in the private sector has typically been 3 to 4 percentage points above consumer price index (CPI), so it would be realistic to raise costs by 9% per annum. That gives us a 2019 PMB cost of R886 pbpm.

If we then apply the 30% discount as calculated by Barry Childs, we achieve a cost per beneficiary of R620.

The breakdown of our calculation thus far is as follows:

PMB cost (2017)	R746 (per beneficiary per month)
Adjusted to 2019 prices (9% pa)	R886 (per beneficiary per month)
Reduced cost without anti-selection (-30%)	R620 (per beneficiary per month)

The above numbers only represent the private sector provision of PMBs and the current PMB package, which excludes any primary care benefits. If we look at an analysis of the work done by the CMS on the Low Cost Benefit Options (LCBO) in 2015 (circulars 37 and 54), which comprised mainly basic primary care benefits, we can see that the expected cost for these services was somewhere between R200 and R400 pbpm.

A note on the PMB package

It is also important to bear in mind that the current PMB package does not provide a fully comprehensive set of secondary/tertiary medical services. Using clinical ICD-10 coding that identifies conditions, the PMB component of most comprehensive medical scheme packages would constitute around 60-70% of total services they cover.

This means that if the NHI uses the PMB package as its own benchmark, there will still be a substantial requirement of additional cover for non-NHI services.

No exact costing was concluded, firstly because it is the business of medical schemes to price their own benefit structures, and secondly, because the plans to introduce the LCBO were shelved prior to their implementation. The only primary care plans that exist within the market today are housed within insurance companies and since the insurance industry does not compile annual reports at product level, there is no publicly available data to rely on for these products.

[9] Presented at the 2015 BHF Annual Conference

However, from assessing product prices in the market place, we can conclude that the above range quoted in circular 37 (R200-R400 pbpm) is reasonably accurate. Much would depend on what benefits were contained between products at the lower end versus products at the higher end of that range, whether they were voluntary retail products or compulsory employee benefits and the rate at which providers were reimbursed by such insurers.

Nonetheless, to be conservative, we can take a pricing from the middle of the bottom quartile of that range, which gives us a treatment cost of R225 pbpm. The costs quoted were 2015 costs, so again we need to adjust these to 2019 prices. Primary care services do not generally increase at the same rate as tertiary and secondary care services, so for the purpose of adjusting these costs to 2019, we used an annual factor of 7% rather than 9%. This would give us an expected cost for a basket of primary care services of R295 pbpm for 2019. We assumed that the data used in the LCBO exercise was from existing medical scheme data which similarly would be subject to the level of anti-selection discussed earlier. It would therefore be appropriate to discount this rate for NHI in the same fashion as we did with the existing PMB costs.

If we use the same discount factor of 30% for the removal of anti-selection, we get a cost for primary care services of R207 pbpm. If we add this to the cost for the derived PMB package that we calculated previously of R620 pbpm, we arrive at an overall cost of R827 pbpm for a PMB package plus primary care benefits.

We can further assume that since the NHI services are to be delivered by a mixture of accredited private and public sector providers, there could be price differences between the two sectors. Public sector providers are not subject to VAT, and capital requirements such as infrastructure maintenance are carried out by the Department of Public Works rather than coming out of their own budgets.

All cost calculations done above were taken from private providers and/or medical scheme data. Considering their lower base costs, there may well be modified tariffs for public providers under NHI. If we assume that the public sector will deliver 75% of national services under NHI and that they can deliver these services at 80% of the cost of the private sector, then we get to the following weighted average benefit cost for NHI:

Private sector	R827 pbpm	Weight = 25%
Public sector (80% of private)	R662 pbpm	Weight = 75%
Average across both sectors	R703 pbpm	Total (100%)

If we multiply this cost by Stats SA's 2018 mid-year population estimate of 57,73 million citizens, we obtain a cost for NHI benefits of R487 billion per annum.

A note on the private sector

The dramatic impact of anti-selection on costs that appeared from the analysis done by Barry Childs in 2015 (referred to in the main body), is very important to note.

The private sector in SA is highly anomalous in that it maintains the consumer aspects of member protection usually seen in social or national systems, namely, open enrolment, community rating and guaranteed payment on minimum benefits. However, universally these systems do not permit voluntary participation since the negative result is the massive anti-selection that Childs' study has highlighted in SA. The SA government has consistently perpetuated the argument, throughout the passage of NHI, that SA's private medical costs are unacceptably high and has likewise driven the narrative that the system unfairly prejudices the poor – hence the need for NHI.

However, government is failing to acknowledge that the regulatory framework it has steadfastly insisted on foisting upon the private sector for the past 20 years has single-handedly been the biggest cause of these massive cost escalations. These regulatory shortcomings have been further highlighted by the Health Market Inquiry (HMI) and we believe it to be disingenuous for government to use these arguments in its favour when it itself was the very cause of the primary maladies afflicting the private sector.

ADMINISTRATIVE AND MANAGEMENT COSTS OF NATIONAL HEALTH INSURANCE

The above cost calculation for NHI services excludes any administrative or management costs. These would entail the administrative process of collecting NHI specific taxes, paying service providers, managing clinical care protocols, operating the Office of Health Standards Compliance to accredit all NHI providers, as well as maintaining the number of committees and departments envisaged within the NHI bill. If we again rely on the average costs within the private sector, we can make some assumptions and determine to what extent the administrative and management costs within the NHI could be.

The average 2017 cost for both administrative and managed care expenses came to R120,21 pbpm for closed medical schemes. We have used the lower costs associated with closed medical schemes since they generally do not carry the higher marketing and sales costs like open medical schemes do.

Considering the advantages the State will have under NHI (no VAT, lower base costs and scale advantage), we can reduce the cost for closed medical schemes by say 30% and get an average operational NHI cost of R84,15 pbpm. If we extrapolate this to 2019 by 6% pa, we get a pbpm cost of R94,55. Extrapolating this to the 2018 population size of 57,73 million, we get to a total operational cost of R65,50 billion per annum. This administrative cost excludes the associated cost of running the OHSC, since no similar process exists within the private sector. However, we take note of the following excerpt on the potential OHSC duties from the submission by the SA Private Practitioners Forum (SAPPF) on NHI:

65) *A further unconsidered cost in the NHI White Paper is the potential escalation in the costs of running the Office of Health Standards Compliance once the NHI is implemented. In clause 38(2)(a) of the Draft Bill, it is indicated that Health Facilities that wish to contract with the NHI Fund would need to be certified by the OHSC in order to do so. According to 2015 claims data from a major medical scheme administrator, there are currently a conservatively estimated 600 clinics in the private sector and at least an additional 32 600 private healthcare practice facilities that would need to be inspected in a four-yearly cycle by the OHSC. Figures provided by Medpages indicate that there are 12 390 Hospitals and clinics registered on their database, with an additional 62 168 registered private practices.*

66) *In 2014/2015, the OHSC inspected 417 government facilities. The number of employees at the OHSC was 96 in 2015/16 and will be increased to 137 in 2017/18. There is no indication in the OHSC Annual Performance Plan document, which extends to 2020, of the creation of inspectorate capacity to inspect the approximately 33 200 to 74 558 private facilities for inclusion in the NHI. No inspection of private facilities has commenced to date in 2018 and the Healthcare facility norms and standards that were promulgated in 2017 create certain requirements for facilities wishing to comply. The OHSC would have to inspect between 8 300 and 18 640 private facilities annually in the 7 years between 2018 and 2025 for possible inclusion and accreditation in the NHI. This is due to a certification from the OHSC only being valid for 4 years.*

67) *With their current staffing complement of 7 inspection teams of 5 inspectors each, this would entail that each team will have to inspect between 5.2 and 11.07 facilities in every working day (of which there are 229 per employee annually). In 2014/15, each team was on average, able to inspect one facility every 4-5 work days. In order to do the necessary inspections, there would have to be between 182 and 388 teams of 5 inspectors employed by the OHSC, giving it a staff complement of between 910 and 1938 inspectors. There is currently no indication in the budget of the OHSC, which is projected up to 2020 in their annual performance review, of the necessary budget availability to increase their inspectorate capacity to these levels. The current inspectorate budget is R28 million per annum, which would need to be expanded to between R227 million and R484 million (average CTC of R250 000 per inspector), which only includes salary costs and does not address the potential escalation in travel and accommodation costs for this inspectorate force.*

68) *There is currently no indication in either the projected NHI costs or the OHSC strategic budget to 2020 of inclusion of these additional funding requirements for the inspectorate to operate as required in the White Paper.*

AFFORDABILITY

It is worth noting now that the total revenue collected from taxes for the 2017/18 fiscal year was R1 216,5 billion and the Department of Health's allocated budget for the 2019/20 financial year was R226 billion.

Tax revenues were broadly split as follows:

Personal Income Taxes	R462,9 billion	38,1%
Company Income Tax	R248 billion	18,1%
Value-Added Tax	R298 billion	24,5%
Other	R207,1 billion	19,3%
Total	R1 216 billion	100%

Source: Tax Statistics, 2018

The shortfall between the National DoH's current budget allocation and the cost for NHI would need to be raised in taxes.

SOUTH AFRICA CANNOT AFFORD NHI

Section 49 of the NHI bill outlines the following sources of revenue for the NHI fund – general tax allocation (existing health budget), reallocation of the medical scheme tax

credits, a payroll tax (employer and employee) and a surcharge on income tax.

The consequences of increasing taxes on workers will be lower take home pay and even job losses. Leaving people and companies with less money for savings and investment, the NHI will usher in even slower economic growth and less job creation, hurting the very group that the NHI scheme purports to assist.

According to the official government statistical agency Statistics South Africa (Stats SA), the official unemployment rate is currently 29% (2Q2019).[10] This equates to over 6,6 million unemployed people in South Africa. However, this is not a very good indicator of what is happening on the ground, since most unemployed people have given up searching for work. According to Stats SA, over two-thirds of the unemployed have been unemployed for more than one year.

A better reflection of the country's unemployment situation is the expanded definition of unemployment, which includes so-called discouraged work seekers. The expanded definition reveals that, in total, about 38,5% of the working-age population are unemployed, which equates to more than 10,2 million unemployed people.[11] A result of this massive unemployment problem is that South Africa suffers not only from relatively low levels of income but also from a very narrow tax base.

According to Tax Statistics 2018, a joint publication by National Treasury and SARS, personal income tax (PIT) is South Africa's largest source of tax revenue and contributed 38,1% of total tax revenue collections.[12] For the 2017 tax year there were an estimated 20 million registered individual taxpayers. Of these 6,4 million were expected to submit tax returns and 4,8 million were assessed.[13] The assessed taxpayers had aggregate taxable income of R1,5 trillion and a tax liability of R321 billion. Their average tax rate was 20,8%, increasing from 19% in the 2013 tax year. If we disaggregate the data, we find that individuals earning more than R500 000 per annum (approximately 926 000 people) accounted for 65,6% of the total income tax assessed. If we include those with a taxable income in excess of R350 000 per annum, we find that approximately 1,7 million people account for 81% of the total personal income tax payments. In summary, 2,9% of the population contributes 81% of personal income tax.

It should be clear that South Africa has a very narrow tax base. It would be extremely unwise for government to even consider imposing another tax on already overburdened taxpayers rather than trying to get more people actively involved in the workforce, and adopting policies that will lead to increased economic growth. Since the main funding option for the NHI scheme will necessarily come from a surcharge on taxable incomes and a payroll tax, the NHI is nothing but a tax on labour. A payroll tax will always, ultimately, be borne by workers, either through reduced compensation or earnings or job losses – precisely the opposite of what the poor in South Africa require.

While the NHI scheme is supposed to help people access medical care, it would instead undermine their chances of economic success by either cutting their wages or eliminating their jobs altogether. In short, adopting the proposed NHI has the potential to wreck South Africa's already weak economy.

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[10] Statistics South Africa. 2018. *Quarterly Labour Force Survey, Quarter 2: 2018. Statistical Release: P0211.* Available at http://www.statssa.gov.za/publications/P0211/P02112ndQuarter2018.pdf.

[11] Ibid.

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