OUTA

ORGANISATION UNDOING TAX ABUSE

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Removing Barriers to Universal Health Coverage:

Four Areas of Concern in the NHI Bill

Submission to the Portfolio Committee on Health

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Abbreviations

ACA	Anti-Corruption Agency
AU	African Union
CUP	Contracting Unit for Primary Health Care
DHMO	District Health Management Office
DPHO	District Public Health Office
NDP	National Development Plan
NHI	National Health Insurance
NHS	National Health Service
NHSCFA	National Health Service Counter Fraud Authority
OUTA	Organisation Undoing Tax Abuse
PHC	Primary Health Care
PFMA	Public Finance Management Act
SARS	South African Revenue Service
SDGs	Sustainable Development Goals
UHC	Universal Health Coverage
UN	United Nations
USC	User Service Centres
WHO	World Health Organization

Executive summary

The Organisation Undoing Tax Abuse (OUTA) is a civil society organisation dedicated to working for a better South Africa.

As an organisation, we fully support the objective of Universal Health Coverage (UHC). However, we believe that the National Health Insurance (NHI) Bill [B11-2019], as currently presented, has several major flaws that call for an urgent revision – without such revision the long-term goal of UHC will remain tragically out of reach for South Africans.

Our concerns pertain to the need to ensure that the NHI Fund itself is impervious to corruption, that maladministration in the health districts is prevented, that citizens are spared from excessive taxation under the NHI dispensation and that the rights of all health service users (including vulnerable groups) are respected.

To this end we propose the following revisions:

1) To **protect the NHI Fund from corruption**, we propose that a) there be the establishment of an independent NHI Anti-Corruption Agency (as a "Red Scorpions"), and that b) more oversight be given to Parliament in terms of the appointment and accountability of the NHI Board.

2) To **protect the health districts from maladministration** we propose that a) District Health Management Offices (DHMOs) be designated as "accounting authorities" in terms of the Public Finance Management Act (PFMA), and b) District Public Health Offices (DPHOs) be established to support cost-effective purchasing of health services for citizens.

3) To **protect the rights of taxpayers** we proposed that a) the role and powers of the Stakeholder Advisory Committee be clearly defined so as to combat tax

abuse, and b) surcharges on personal income tax be limited or removed as a source of revenue for NHI (until fiscal management and accountability of government is improved).

4) To **protect the rights of health service users** we propose that a) well-supported and accessible User Service Centres be established in each health district and b) active asylum seekers be allowed to register as NHI users.

We present this written submission to the Portfolio Committee on Health in the hope that it will urgently address some of the major limitations of the NHI Bill and help in the path towards UHC for our country.

Introduction

The Organisation Undoing Tax Abuse (OUTA) is a civic action organisation focused on working for a better South Africa. We do so by tackling corruption and maladministration, and by engaging with government (as part of civil society) on issues relating to legislation and policy. OUTA is supported by ordinary citizens who are passionate about the future of our country. Our values are integrity, resilience, courage, tenacity, humility, honesty, inclusiveness and accountability. OUTA is strictly non-profit and non-partisan. We aim to work for the betterment of all South Africans.

At the outset, OUTA would like to state that we support the ideal of Universal Health Coverage (UHC). Indeed, we believe that UHC is both a social and moral necessity for our country. Its achievement should be non-negotiable and it is, therefore, a rightful policy priority for national government.

According to the World Health Organization (WHO), the goal of UHC is three-fold: it aims to provide 1) as wide a range of health services as possible to 2) the greatest coverage of a population while ensuring 3) a maximum reduction in financial risk resulting from disease or injury.[1] These three dimensions can be expressed in the form of a UHC "cube", as shown in in the diagram below.[2]

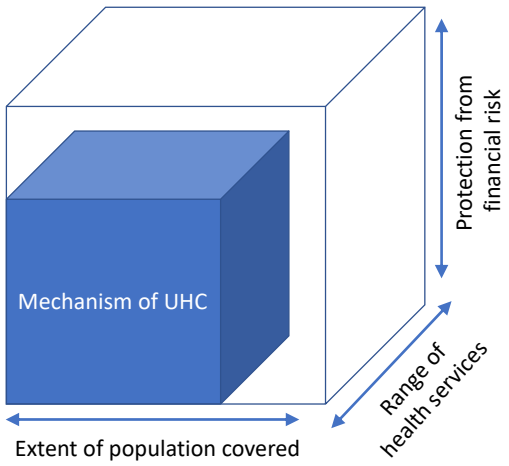

Diagram showing the three dimensions of the UHC "Cube"[2]

The third dimension is particularly important in our context: in short, no person living in South Africa should have to face financial ruin because they have a particular illness or injury.

The objective of UHC is underpinned in the provisions of Section 27 of the Constitution. Furthermore, it aligns with key strategies at domestic (the National Development Plan), continental (the African Union Agenda 2063) and international (the UN Sustainable Development Goals) levels. This is shown in Table 1.

Strategic Agenda	UHC-related target
National Development Plan (NDP) [3]	*NDP Action 71, Implement NHI:* "Implement the scheme in a phased manner, focusing on: - Improving quality of care in public facilities - Reducing the relative cost of private medical care - Increasing the number of medical professionals - Introducing a patient record system and supporting information technology systems."
AU Agenda 2063 [4]	*Agenda Goal 3:* "Healthy and well-nourished citizens"
Sustainable Development Goals [5]	*SDG Target 3.8:* "Achieve universal health coverage, including financial risk protection, access to quality essential health-care services and access to safe, effective, quality and affordable essential medicines and vaccines for all."

Table 1: UHC in relation to national, continental and global policy strategies

However, it is important to distinguish between UHC and National Health Insurance (NHI) – UHC is the long-term, over-arching policy goal for our country's health system while NHI is a specific funding model. Indeed, in a recent provincial presentation to Parliament's Portfolio Committee on Health, it was stated that:

> "The aim of the NHI is to achieve UHC but UHC can be achieved without the NHI. [Twenty four] developing countries like Thailand, Mexico, Argentina, Brazil, among others have successfully implemented UHC using various funding mechanisms. Each of the countries adapts unique funding models to achieve UHC for its citizens." [6]

This is not to say that a mechanism such as NHI shouldn't be used – it simply underscores the importance of keeping UHC as the ideological ideal in a way that allows for a great degree of pragmatism with regards to the funding mechanism. Moreover, we should take as much time and liberty as is necessary to shape (and reshape) the funding mechanism so that it actually allows us to move towards the long-term destination of UHC. This may, indeed, require large-scale revisions to the NHI Bill in its current form.

Challenges to NHI implementation

Historical and contextual challenges

Perhaps the single biggest challenge facing NHI implementation is fact that South Africa has a highly fragmented health system, with a severely under-resourced public health service sector. This has resulted, to a large extent, from the systemic disregard of basic rights in our nation's past.

There are deep historical factors underlying South Africa's current health system deficiencies. Prior to 1994, Apartheid policies deeply divided our health system along racial lines, propagating structural inequalities and perpetuating health injustices across generations. Furthermore, our newly elected democratic government inherited a two-tiered health system in 1994 in the form of a well-resourced private health sector and an over-stretched and under-serviced public health sector. [7]

The NHI Green Paper described the disparate state of our health systems in 2011 (which hasn't changed significantly since) as follows:

> "The 8.3% of GDP spent on health is split as 4.1% in the private sector and 4.2% in the public sector. The 4.1% spend covers 16.2% of the population (8.2 million people), who are largely on medical schemes. The remaining 4.2% is spent on 84% of the population (42 million people) who mainly utilize the public healthcare sector." [8, pg. 9 -10]

While these proportions have been debated, what is incontrovertible is the following: we have a deeply divided health system where the majority of the population have access to a public health service that is severely strained – from health facilities to financial and human resources – as compared to the private sector.

A UHC model appropriate to the South African context should be cognizant of this disparity; in doing so, it would aim to leverage off the strengths of the private sector to improve services in the public sector without compromising the quality of care offered to all citizens.

This isn't to say that there aren't systemic problems in the private sector – indeed, the recent Health Market Inquiry,[9] undertaken by the Competition Commission, bears testimony to this.[a] However, it would seem generally desirable that *all* citizens (regardless of their socio-economic situation) should be able to, in a UHC system, access health services of a quality that is at least comparable to that which currently exists in the private health sector.

NHI roll-out challenges

The above notwithstanding, poor administration appears to have hampered attempts to roll out the NHI to date. Firstly, there appears to have been considerable policy delay – the 2011 Green Paper plotted a timeline that was to see the initial NHI White Paper released for comment in August 2011, and the NHI legislative process commence in January 2012. However, the NHI White Paper was eventually only released in June 2017[10] and the NHI Bill, in its current iteration, was only presented in July 2019.[11] This inertia raises questions of political will and policy uncertainty.

Secondly, there have been considerable challenges regarding NHI expenditure to date. For example, only about 10% of NHI's indirect grant allocated by the National Department of Health was spent in 2018/19.[12] Although a number of factors have contributed to this (such as problems with GP contracting in the past[13]), it still represents a massive under-expenditure and casts considerable doubt on NHI roll-out processes.

Thirdly, there have been considerable shortfalls in the NHI Pilot programme. A recent report, focused on the 11 NHI Pilot Districts, revealed a range of serious problems involving essential components of primary health care (PHC), such as impediments to ward-based outreach teams and integrated school health programmes, as well as more general health system challenges (including a lack of needed IT infrastructure in health facilities).[14,15] These shortfalls surely need to be addressed before full NHI implementation is attempted.

[a] The recommendations of the inquiry are wide-reaching, and speak to issues of transparency and accountability needed in the private sector in order to move towards the national policy goal of UHC.

Finally, there has been a lack of clarity around the actual funding of the NHI. Estimated costs have ranged widely from R165 billion to R450 billion (with a government estimate of R259 billion).[16] What is certain, though, is that current fiscal restraints may greatly decrease the affordability of the NHI. Indeed, in his recent Medium-Term Budget Policy Statement, the Minister of Finance admitted that:

> "… given the macroeconomic and fiscal outlook, the estimates to roll out NHI that were published in the NHI Green Paper in 2011 and White Paper in 2017 are no longer affordable."[17]

All of the above has resulted in a level of uncertainty that has affected the public's confidence in (and, by extension, the potential of social support for) the NHI. More specifically, the perceived lack of clarity in communication has contributed to considerable unease amongst health professionals. Indeed, there appears to be a very real risk of a "brain-drain" if this uncertainty is not addressed.[18]

OUTA's four points of concern

In addition to the general issues discussed thus far, OUTA has four main concerns that we would like to submit to the Portfolio Committee for consideration. This is based largely on our assessment of both the context and content of the NHI Bill. It is also informed by the written comments that we have received, as a civil society organisation, from the public on the subject.

1. The need to protect the NHI Fund from corruption

To say that corruption in South Africa is a major challenge is a gross understatement, as it appears to be endemic in our country – with an estimated cost to the GDP of R27 billion annually and a loss of 76 000 jobs.[19]

Corruption has detrimental effects on efforts to achieve democratic stability, societal sustainability, economic growth and development of the country. It is one of the biggest threats to achieving UHC. It can take money away from healthcare, leading to poorer quality of care, making access to healthcare unfair and disproportionately affecting the poor. It impedes health care outcomes by reducing government funding available for health services resulting in inadequate service delivery and scarce resources being wasted.[20]

The NHI Fund will represent a colossal sum of public money. Therefore, if the Fund is not meticulously governed within a strict accountability framework of checks and balances, there may be vulnerability to corruption with the risk of unprecedented levels of damage to our society.

To this end, it is encouraging to see that an Investigating Unit is proposed in the Bill. However, this Unit will potentially be severely limited in that it will be an internal body that forms part of the Chief Executive Officer's office. As such, it will not be able to conduct truly independent investigations, which can greatly reduce its ability to combat corruption.

2. The need to protect health districts from maladministration

Even if the Fund is governed with the highest level of accountability, massive losses can still occur if health districts and sub-districts (as key recipients of NHI funding) are not also carefully managed. Indeed, this may become analogous to the widespread failure of municipalities, as reported by the Auditor-General,[21] highlighting the many potential weaknesses that still exist in our cooperative government arrangements. It is, therefore, imperative that DHMOs, as key controlling bodies, be subjected to stringent accountability mechanisms.

Furthermore, districts are comprised of patient populations that deserve the best management in terms of public health. In relation to this, a professional public health workforce can greatly enhance district management by supporting effective and efficient health purchasing decisions. This, in turn, can significantly mitigate the risk of maladministration. However, the need to develop district public health capacity appears to be largely absent in NHI discussions and is certainly not mentioned in the Bill.

3. The need to protect the rights of taxpayers

South Africa is already a highly taxed society. Indeed, South African citizens carry one of the highest burdens by international comparison.[22] A serious concern, then, is that the NHI will represent yet another layer of taxation that may push households who are presently at the economic margins over the proverbial brink. Moreover, there is the concern that this extra taxation – together with the loss of medical aid tax credits – will not actually provide a yield in terms of accessible and quality health services, placing households at further peril.

In addition to the above, better management of the fund through good governance mechanisms could mitigate the risk of tax abuse. This may require the development of multi-stakeholder, and innovative, approaches to operational oversight.

4. The need to protect the rights of health service users

OUTA believes that if the NHI is to succeed, it must be grounded on a rights-based approach.

One of our major concerns is around patients' rights. This includes the ability to access a wide range of health services, in a reasonably short period of time, and in a context that is professional and caring. Key issues here relate to quality of care and short waiting times throughout the patient's journey. Furthermore, patients would like to be able to make informed decisions about their health services and have consistency in their health-care provision.

Patients would also want to have a clear line of recourse in terms of complaints and reporting of suspected malfeasance in health services. Moreover, they would like to actively participate in shaping health services that are accessible, appropriate and equitable.

Broader than patient rights, the respect of human rights must be inherent to any legitimate health system. Ensuring the protection of these rights should, therefore, be an essential part of the NHI dispensation. Here, the access that vulnerable groups, such asylum seekers, have to health services should be carefully considered.

In the following sections, OUTA will provide possible revisions relating to the four areas of concerns that have been described above.

Concern 1: Protecting the NHI Fund from corruption

1a) The need for an independent anti-corruption agency

As relating to the following chapter and section of the NHI Bill:

- Chapter 5, Section 20

Section 20 of the Bill articulates that, subject to the direction of the Board, the Chief Executive Officer must establish an Investigating Unit to ensure that corruption is addressed in the health sector. However, the Bill does not elaborate sufficiently on the functions of the Unit.

In light of the above, OUTA proposes that an "arms-length" Anti-Corruption Agency (ACA) be established to monitor and prevent corruption in the health-care sector. A single agency model is proposed for the ACA with its activities arranged around the following three key pillars: investigations, prevention, and public outreach and education.[23] In line with this model, OUTA proposes that the ACA should be implemented with a multi-purpose mandate that includes the:

- Development of anti-corruption policy proposals;
- Coordination, monitoring and knowledge-creation through research on corruption;
- Prevention of corruption in power structures;
- Implementation of anti-corruption awareness and education; and
- Investigation and prosecution.

Reference can be made to the South African Revenue Services (SARS) enforcement agency which, in turn, is based on the approach introduced by the Organisation for Economic Co-operation and Development as a tax-compliance model.[24] The aim of this approach is to ensure that the SARS enforcement agency has power to prevent

corruption, investigate corruption and educate and create awareness on corruption. Therefore, OUTA proposes that the ACA adopts a function similar to the SARS enforcement agency.

Another example we can refer to is the United Kingdom's National Health Service (NHS) Counter Fraud Authority (NHSCFA) which was established on 1 November 2017 as a centre of excellence for combating fraud, bribery and corruption.[25] Its staff members include specialists in intelligence, fraud prevention, computer forensics, fraud investigation, financial investigation, data analysis and communications. The NHSCFA delivers a range of specialised services to tackle NHS fraud, including:

- Intelligence;
- Investigations;
- Fraud prevention;
- Standards;
- Staff and organisational development;
- Communications; and
- Digitalisation and technology.

The NHSCFA was established following an assessment indicating an economic loss of £1.29 billion due to NHS fraud. It is an independent authority reporting to the United Kingdom's Parliament.

When comparing the proposed NHI Bill and its limited anti-fraud and fraud prevention strategies and mechanisms to its United Kingdom counterpart, the NHSCFA, there is still much to be done to protect the NHI Fund. This is especially so taking into consideration South Africa's current fiscal climate and, if the NHSCFA is an indicator, the potential loss South Africa may suffer if proper protection is not put in place.

As in the case with the South African NHI Bill, the United Kingdom's NHS first made provision for an "in-house" anti-fraud mechanism. However as from 1 November 2017,

the *NHS Counter Fraud Authority Order 2017* [26] provided for the establishment of the new special health authority to exercise the statutory functions of the Secretary of State in relation to the prevention, detection and investigation of fraud affecting the health service in England.

Prior to 1 November 2017, these functions, together with the security management functions of the Secretary of State in relation to the health service, were exercisable by a division of the NHS Business Services Authority (also a special health authority). The *Order 2017* removed both counter fraud and security management functions from the NHS Business Services Authority and placed it with the NHSCFA. This ensured less interference and more independence in fraud prevention, detection and intervention.

In light of the examples of the SARS enforcement authority and the NHSCFA, the NHI ACA should be established as an independent body dedicated to fight corruption, fraud and maladministration in the health care sector. In can exist as a well-resourced "Red Scorpions" agency.

For the ACA to function effectively, it must have independence. It has been argued that the intensification of anti-corruption efforts in South Africa cannot be successful unless the relevant agencies are independent from political influence.[27] To ensure that the ACA has sufficient autonomy, political interference should be minimised in terms of:

(a) Appointment of ACA authorities;

(b) Implementation of functions and decision making on anti-corruption strategies;

(c) Functional meaning; and

(d) Budget allocation of the agency.

OUTA proposes that the Investigating Unit as envisioned in Section 20 of the Bill should be differentiated from the proposed ACA. More to the point, the ACA can serve

as the independent oversight body of the NHI Fund (this will require the role of the Investigating Unit to be modified accordingly). The Bill should also outline the process for key appointments in the ACA and should provide for representation of the agency at all levels (that is, from national to district levels).

Consideration for revision:

- That Chapter 5 of the NHI Bill be revised so as to establish an independent Anti-Corruption Agency that is differentiated from the Investigating Unit.

1b) Preventing capture of the NHI Fund

As relating to the following chapter and section of the NHI Bill:

- Chapter 4, Section 12
- Chapter 4, Section 15

Section 12 of the NHI Bill implies that the Board of the NHI Fund will be solely accountable to the Minister. OUTA contends that this exclusive approach to governance has proven to be ineffective and susceptible to corruption. Whilst it is essential that the provisions of the PFMA are applicable here, there is an ongoing debate regarding the appropriateness of corporate governance models for major state-owned companies and entities.[28]

The Board must, in any respect, be more fully accountable to appropriate parliamentary oversight committees which, in turn, should be sensitive to concerns and preferences of ordinary citizens.[b]

[b] Section 13 of the 2018 version of the NHI Bill established the Board of the Fund as "…an independent Board that is accountable to Parliament". The reasons for the removal of the word "independent" and

Section 15 outlines the functions and powers of the Board. It is inconceivable that a group of not more than 11 persons appointed by a single politician, who need not meet more than four times per annum, should be solely responsible for the entirety of the Fund's operational, financial and administrative policies and practices.

The NHI Fund is ultimately set to consist of hundreds of billions of rand. Eskom is a good example of why such an amount of money should not be left under the purview of a small group of people and a single Minister at any given point in time – regardless of their competence. Instead, Section 15 can be amended to provide for a much more decentralised governance model that includes substantive parliamentary scrutiny, as well as (possibly) the Minister of Finance.

Consideration for revision:

- That Chapter 4 of the NHI Bill be revised so that Parliament is clearly included in the appointment and accountability of the Board of the NHI Fund.

substitution of Parliament with Minister are unclear. OUTA submits that every measure should be taken to ensure the independence of the Board whilst still allowing for adequate oversight and accountability.

Concern 2: Protecting health districts from maladministration

2a) Reviewing the role of District Health Management Offices

As relating to the following chapter and section of the NHI Bill:

- Chapter 8, Section 36

Section 36 of the NHI Bill describes the role of DHMOs in terms of the provision of PHC services in each district. The schedule for repeals and amendments (Section 58) then details the exhaustive role of DHMO under the envisioned amendments to the National Health Act.

Given the scope of the DHMO, maladministration at this level could prove disastrous for NHI implementation. Indeed, parallels could be drawn between DHMOs and municipal authorities in that each serve as local sites of service delivery coordination. To this end, sobering lessons can be learned from the crisis of municipal failures. Indeed, a report by the Public Affairs Research Institute on collapsed municipalities made the following observation:

> "Often the causes of these problems can be traced to maladministration, corruption and theft of public assets… There is little regard for even the most basic principles of good governance or the needs of the wider community."[29, pg.1]

To prevent this scenario from occurring in relation to DHMOs, it is essential that appropriate safeguards be put into place. More specifically, there needs to be transparency, accountability and clear consequence management for any instances of poor governance as this could have a devastating impact on the health of communities within health districts.

In Canada (where UHC is well-established) the first principle of the five Canada Health Act principles is "Public Administration", on the basis of which:

> "[T]he provincial and territorial plans must be administered and operated on a non-profit basis by a public authority accountable to the provincial or territorial government." [30]

This allows for provincial and territorial (local) governments to plan and execute, through an authority, their obligations and, importantly, helps to ensure accountability. The South African NHI Bill does not, presently, allow for a similarly structured and codified approach to holding authorities accountable.

On the basis of the points raised above, it is recommended that DHMOs be designated as "accounting authorities" in terms of the PFMA. While it is understood that, according the Bill, the NHI Fund Board is assigned the role of the accounting authority for the entire Fund (for which it appears to be, to an extent, answerable to Parliament),[c] DHMOs should also be held accountable for NHI funding allocated to their respective health districts.

To this end, each DHMO could be answerable to their relevant provincial Legislatures for the NHI funds disbursed to it and would have to exercise the functions assigned to accounting authorities in this regard. This would include financial and risk management of all Contracting Units for Primary Health Care (CUPs) within their districts, in accordance with the principles of the PFMA.

Consideration for revision:

- That Chapter 8 of the NHI Bill include the designation of District Health Management Offices as accounting authorities in terms of the PFMA.

[c] According to paragraph 6.12 of the Memorandum on the Objects of the NHI Bill, 2019, the Board is accountable to the Parliament in terms of the PFMA. There needs to be a clarification on this point, as this appears to contradict Section 15 of the Bill which makes the Board answerable to the Minister as an accounting authority.

2b) Strengthening district public health capacity

As relating to the following chapter and sections of the NHI Bill:

- Chapter 8, Section 35
- Chapter 8, Section 37

Section 35 of the NHI Bill describes the strategic purchasing of health services, and stipules that this should be done in accordance with the needs of users. It also highlights the role of CUPs in making such purchases. In Section 37, more detail is given to the role of CUPs at sub-district level. Their duties include managing health service contracts, and the integration of the public and private provision of PHC within sub-districts.

The CUPs are also given the responsibility to "identify health care service needs in terms of the demographic and epidemiological profile of a particular sub-district". However, no mention is made in the Bill of the public health capacity that would be needed to build such profiles at either sub-district or district levels. This is a significant oversight as such public health capabilities would be critical for guiding health planning and purchasing decisions (and, by extension, the proper administration of health districts).

In the health systems of many other countries, provisions have been made for "Medical Officers of Health" who have essential public health functions with respect to local patient populations. In Kenya, for example, District Medical Officers of Health play a vital role in planning public health interventions in districts;[31] in the United Kingdom, Directors of Public Health in the NHS are tasked with health protection and promotion within local authorities;[32] and in Canada, the duties of Medical Officers of Health include the mitigation of public health emergencies.[33] In all of these examples, the role of the public health officer is filled by a suitably qualified health professional, and includes health surveillance and the provision of epidemiological information in the local context.

In light of the above, it is proposed that a District Public Health Office (DPHO) be established within each health district. This office should be led by a District Public Health Officer who should be suitably qualified public health medicine specialist and who will oversee a district workforce of public health professionals.

The DPHO can be tasked with providing a wide range of services to the district, such as health systems analysis, epidemiological surveillance, public health emergency coordination and the delivery of preventive medical services. However, while these would require separate regulations (and even amendments to legislation such as the National Health Act), for the purposes of the NHI Bill the role of the DPHO can be largely described in terms of providing demographic and epidemiological information to CUPs, with reference to Section 35. This will help to ensure evidence-based and cost-effective health planning, thereby reducing the risk of maladministration at sub-district and district levels.

Consideration for revision:

- That Chapter 8 of the NHI Bill includes the establishment of District Public Health Offices whose duties will include providing technical support for Contracting Units for Primary Health Care, ensuring evidence-based and cost-effective purchasing of health services.

Concern 3: Protecting the rights of taxpayers

3a) Protection through good governance

As relating to the following chapters and sections of the NHI Bill:

- Chapter 7, Section 27
- Chapter 8, Section 31
- Chapter 8, Section 32

In South Africa the abuse of taxpayers' money occurs far too frequently, resulting from poor governance and culminating in inadequate service delivery. Poor governance is characterised by corruption and financial mismanagement which drain our resources and present a significant barrier to development. One of the root causes of systemic tax abuse is a lack of information exchange between government, civil society, the private sector and academia.

Therefore, an innovative and robust governance and accountability model is required to lead and oversee the operations of the Fund sustainably, and to prevent the risk of tax abuse. Some common causes of poor governance across all state-owned enterprises comprise of:

- Failure of accounting and executive authorities to clearly delineate and separate public and private interests when conducting government business; this speaks to Section 31 (1) and (2) of the NHI Bill, which places this very responsibility solely in the hands of a single Minister.
- Failure to establish enforceable guidelines of behaviour for public service providers and staff that are conducive to sustainable economic development.
- Ideological priorities inconsistent with sustainable economic development, resulting in misallocation and misspending of resources.

The above notwithstanding, a good governance model could transform the public healthcare system by providing access to quality healthcare services in an effective and efficient manner.

Good governance must be enforced by:

- Accountability and transparency, as reflected by audit outcomes and effective structural oversight mechanisms;
- Stakeholder participation, that should incorporate academic and civil thinking in the operations and management of the Fund; and
- Shared direction and "social solidarity", that can be ensured by the aforementioned.

OUTA believes that the role of the Minister as outlined in Section 31 should be augmented by a decentralised, multisectoral network that consists of civil society, academia, the private sector and government representatives.

Section 32 (2) prospectively empowers the Minister to bring necessary amendments to the existing National Health Act to Parliament "for the purpose of centralising the funding of health care services as required by this Act".

OUTA appeals to the Committee to amend this section to include a role for the multisectoral network. Specifically, the network can have an advisory function with respect to the governance of the decentralised service providing entities described in Section 32 (2). The powers of the Minister of Health notwithstanding, contemplation can also be given to a complementary role for the Minister of Finance in terms of Section 31 (1b); here, an advisory role can again be prescribed for the multisectoral network. All of these measures could help to broaden accountability and strengthen the governance of the Fund.

To harmonise with the existing narrative of the Bill, it is argued that the multisectoral network, as described above, should be fully articulated as the Stakeholder Advisory

Committee described in Section 27 (with clear definition given to its composition and functions, accordingly).

Consideration for revision:

- That Chapter 7 of the NHI Bill be revised to provide the Stakeholder Advisory Committee with clearer definition and substantial governance powers as a multisectoral network aimed at combating tax abuse.

3b) Protection from Excessive Taxation

As relating to the following chapter and section of the NHI Bill:

- Chapter 10, Section 49

Section 49 states that the Fund is entitled to money appropriated annually by Parliament. Its subsections then outline where the money is to be sourced, including:

- "General tax revenue, including shifted funds from provincial equitable share and conditional grants
- Reallocation of funding for medical scheme tax credits
- Payroll tax (employer and employee)
- Surcharge on personal income tax."

As noted by the Financial and Fiscal Commission, these sources of income are not clear.[34] For example, the Bill is entirely unclear as to what proportion each source will contribute to the total Fund. Furthermore, does the provision in the Bill that indicates portions of income tax will be earmarked for use by the Fund mean that National Treasury will actually be willing to ringfence money for this purpose?

Further to the increased tax burden, there is the concern that out-of-pocket expenditure will remain a major challenge for citizens. A survey conducted in Ghana,

for example, showed that a substantial proportion of the population still faced financial risk related to health care. Despite the National Health Insurance Scheme of Ghana being designed to promote UHC, out-of-pocket expenses as a proportion of total health expenditures remain elevated at 26%, exceeding the WHO's recommendations of less than 15–20%.[35]

This reality means that, in South Africa, the tax burden will increase under NHI even while out-of-pocket expenses remain a significant risk – this could cause financial distress for many households already at the economic margins.

OUTA strongly urges government to reconsider simply resorting to surcharges on existing personal income tax as a source of NHI funding. Firstly, there appears to be no clear cap on this amount. Secondly, the imposition of such an open-ended source of taxation has the potential of placing (particularly economically-marginalised households) at real financial risk, thereby countering one of the main pillars of PHC.

Furthermore, we know that large amounts tax revenue have been wasted due to corruption and maladministration. Estimates of what state capture has cost South African taxpayers since 2015 range from R500 billion to R1.5 trillion.[36] Surcharges can only be justified by proven efficiency and accountable, transparent financial management in government.

Consideration for revision:

- That Chapter 10 of the NHI Bill be revised to limit or remove surcharges on personal income tax as a source of revenue at this stage. This can be amended in the future, if fiscal management and accountability are demonstrably improved.

Concern 4: Protecting the rights of health service users

4a) General user rights

As relating to the following chapters and sections of the NHI Bill:

- Chapter 2, Section 6
- Chapter 9, Section 42

The NHI Bill provides a description on the rights of users in Section 6. This includes several entitlements, including (but not limited to):

- The receipt of health care services, of appropriate quality, from accredited providers;
- Access to information pertaining to both the Fund itself and the health service benefits it allows for;
- The submission of complaints pertaining to health services and suspected fraud relating to the Fund; and
- The entitlement of a user to make “reasonable decisions about his or her health care” and to have access to services within a “reasonable period of time”.

However, there is some doubt as to the practicality and, indeed, the potential realisation of these entitlements in the Bill in its current form. Indeed, the complaints procedure as described in Section 42 requires a complex process in which an affected user’s complaint would have to go through the Investigating Unit, which may sit at a level of considerable abstraction from the perspective of the patient.

Any grievance in terms of the outcome of a complaint review process would have to be referred to an Appeal Tribunal (Section 43) which, again, is far removed from the citizen. Furthermore, it is likely that both the Investigating Unit and Appeals Tribunal will be inundated with complaints and appeals from citizens across the country –

making the 30-day and 60-day turn-around periods, respectively, almost impossible to maintain.

OUTA submits that it is far better to establish, within each health district, a NHI User Service Centre (USC). The USC will be tasked with ensuring that there is unhindered access for citizens within the health district in relation to any complaint of health service provision.

This would be in the form of “walk-in” facilities as well as access through appropriate, secure information and communication technologies (such as secure telephonic lines and e-mail addresses). Furthermore, each USC will have to adhere to a strict “whistle-blower” policy that allows for the protected reporting of suspected corruption and maladministration.

The USCs could also communicate relevant health information (such as the expertise of health providers accessible in the district as well as standards and norms in relation to waiting times) so that each citizen can, indeed, make “reasonable decisions about his or her health care” and have access within a “reasonable period of time.”

Another important consideration is the role that users themselves should play in shaping health services within the NHI system, particularly at district level. Here, an appropriate model can be found in the Scottish Health Council. This organisation, which forms part of the NHS in Scotland, facilitates participation by the patients and the public in key areas of NHS delivery, including reviewing NHS service planning and performance, managing changes or improvements in service delivery, and developing networks and volunteering programmes.[37]

With cognizance of this model, it is also recommended that District Service Users Committees be established, to fulfil a support and/or governance role with respect to each USC.

Consideration for revision:

- That Chapter 2 of the NHI Bill includes a provision for the establishment of User Service Centres within each district, supported by District Service Users Committees.

4b) Asylum Seeker Rights

As relating to the following chapter and sections of the NHI Bill:

- Chapter 2, Section 4
- Chapter 2, Section 5

OUTA finds the exclusion of asylum seekers from registration as NHI users (Section 5) and the explicit prohibition of asylum seekers from the utilisation of services except for emergencies and conditions of public health importance (Section 4) to be both morally indefensible and fiscally irresponsible.

This approach is morally indefensible for clear reasons. Asylum seekers have fled their countries of origin and have followed due process in terms of appealing for refugee status.[38] As such, these often represent highly vulnerable communities facing considerable distress. Furthermore, there were only 184 976 active asylum seekers in South Africa as of the end of 2018.[39] This represents a mere fraction (0.3%) of South Africa's estimated mid-year population in 2018 (57.7 million).[40] Even with constrained resources, it would seem highly unlikely that such a small population size would put undue strain on the NHI Fund.

This is also fiscally irresponsible for, again, obvious reasons. Managing an asylum seeker with diabetes mellitus at the PHC level, for example, is far more cost-effective than treating a diabetic emergency (such as managing a patient with diabetic ketoacidosis in an intensive care unit at a tertiary level hospital). Waiting for patients

to develop such emergencies before treatment is not only grossly unethical but is also an extremely poor management of public funds.

Consideration for revision:

- That Chapter 2 of the NHI Bill be amended to allow active asylum seekers to register as NHI users.

Conclusion

OUTA would like to reiterate our strong support of the long-term goal of UHC. Indeed, it is our determination, as a civil society organisation, to provide social solidarity for this objective that has motivated us to address some of the major challenges observed in the NHI Bill.

In our submission, OUTA has identified four main areas of concern, namely protecting the NHI Fund from corruption, protecting health districts from maladministration, protecting the rights of taxpayers and protecting the rights of health service users. We have also provided areas of consideration for revising the NHI Bill with respect to each area of concern.

We appeal to the Portfolio Committee to consider these revisions as we believe that they could help to remedy some of the major deficits in the NHI Bill as currently presented.

Submission to the Portfolio Committee on Health on behalf of the Organisation Undoing Tax Abuse, in reply to the call for written submissions on the National Health Insurance Bill [B11-2019].

29 November 2019

Submission complied by Dr Heinrich Cyril Volmink assisted by Matt Johnston, Ndangano Mashashane, Christopher Scholtz, Soretha Venter and Thabile Zuma.

Annexure: Summary of concerns and proposed revisions

Specific area of concern	Affected chapters and sections	Considerations for revision
1. Protecting the NHI Fund from corruption		
1a) The need for an independent agency	Chapter 5, Section 20	That Chapter 5 of the NHI Bill be revised so as to establish an independent Anti-Corruption Agency that is differentiated from the Investigating Unit.
1b) Preventing capture of the NHI Fund	Chapter 4, Section 12 Chapter 4, Section 15	That Chapter 4 of the NHI Bill be revised so that Parliament is clearly included in the appointment and accountability of the Board of the NHI Fund.
2. Protecting health districts from maladministration		
2a) Reviewing the role of DHMOs	Chapter 8, Section 36	That Chapter 8 of the NHI Bill include the designation of District Health Management Offices as accounting authorities in terms of the PFMA.
2b) Strengthening district public health capacity	• Chapter 8, Section 35 • Chapter 8, Section 37	That Chapter 8 of the NHI Bill includes the establishment of District Public Health Offices whose duties will include providing technical support for Contracting Units for Primary Health Care, ensuring evidence-based and cost-effective purchasing of health services.
3. Protecting the rights of taxpayers		
3a) Protection through good governance	• Chapter 7, Section 27 • Chapter 8, Section 31 • Chapter 8, Section 32	That Chapter 7 of the NHI Bill be revised to provide the Stakeholder Advisory Committee with clearer definition and substantial governance powers as a multisectoral network aimed at combating tax abuse.
3b) Protection from excessive taxation	Chapter 10, Section 49	That Chapter 10 of the NHI Bill be revised to remove surcharges on personal income tax as a source of revenue at this stage. This can be amended in the future, if fiscal management and accountability are demonstrably improved.
4. **Protecting the rights of health service users**		
4a) General user rights	• Chapter 2, Section 6 • Chapter 9, Section 42	That Chapter 2 of the NHI Bill includes a provision for the establishment of User Service Centres within each district, supported by District Service Users Committees.
4b) Asylum seeker rights	• Chapter 2, Section 4 • Chapter 2, Section 5	That Chapter 2 of the NHI Bill be amended to allow active asylum seekers to register as NHI users.

References

1. World Health Organization. Universal Health Coverage and Health Financing. 2019 [cited 2019 November 28]. Available from: https://www.who.int/health_financing/universal_coverage_definition/en/

2. World Health Organisation. Health Financing for universal coverage. Universal coverage – three dimensions. 2019 [cited 2019 November 28]. Available from: https://www.who.int/health_financing/strategy/dimensions/en/

3. National Planning Commission. National Development Plan 2030. Our future-makes it work. Sherino Printers. ISBN: 978-0-621-41180-5 [Cited 2019 November 28]. Available from: https://www.gov.za/sites/default/files/gcis_document/201409/ndp-2030-our-future-make-it-workr.pdf

4. The African Union Commission. Goals and Priority Areas of 2063.The African Union Commission [cited 2019 November 28]. Available from: https://au.int/agenda2063/goals

5. The United Nations. Sustainable Development Goal 3. Ensure Healthy lives and promote well-being for all at all ages. United Nations Sustainable Development Goal Knowledge Platform. The goals within a goal: Health targets for SDG 3 [Cited 2019 November 28] Available from: https://www.who.int/sdg/targets/en/

6. Parliamentary Monitoring Group. Universal Health Care versus the National Health Insurance. Western Cape Parliamentary Presentation. Parliamentary Monitoring Group. 2019 September [Cited 2019 November 28]. Available from: https://pmg.org.za/committee-meeting/28850/

7. Coovadia H, Jewkes R, Barron P, Sanders D and McIntyre D, Health in South Africa 1: The health and health system of South Africa: Historical roots of current health challenges. Lancet 2009, 374;817-34. Published Online August 25, 2009 [Cited 2019 November 28]. Available from: http://depts.washington.edu/sphnet/wp-content/uploads/2013/01/Coovadia.pdf

8. National Department of Health. National Health Act, 2003 Policy on National Health Insurance. Government Gazette: Department of Health; 12 August 2011. 657. Report No 34523. Available from: http://pmg-assets.s3-website-eu-west-1.amazonaws.com/docs/110812nhi_0.pdf

9. Competition Commission South Africa. Health Market Inquiry. Provisional Findings and Recommendations Report; July 2018 [Cited 28 November 2019]. Available from: http://www.compcom.co.za/wp-content/uploads/2018/07/Health-Market-Inquiry-1.pdf

10. National Department of Health. National Health Act, 2003. National Health Insurance Policy Towards Universal Health Coverage; June 2017 [Cited 2019 November 28]. Available from: http://www.health.gov.za/index.php/nhi-documents?download=2257:white-paper-nhi-2017

11. Republic of South Africa. National Health Insurance Bill. Government Gazette No 42598. Published on 26 July 2019 [Cited 2019 November 28]. Available from: https://www.gov.za/sites/default/files/gcis_document/201908/national-health-insurance-bill-b-11-2019.pdf

12. Business Day. Provinces to get unspent NHI fund to fill critical posts in public healthcare; 20 February 2019 [Cited 2019 November 28]. Available from: https://www.businesslive.co.za/bd/national/2019-02-20-provinces-to-get-unspent-nhi-funds-to-fill-critical-posts-in-public-healthcare/

13. National Department of Health. Briefing to Select Committee on Appropriations. Expenditure on National Health Insurance Grant and NHI Pilot sites 2014/2015; June 2015 [Cited 2019 November 28]. Available from: http://pmg-assets.s3-website-eu-west-1.amazonaws.com/150609health.ppt

14. Evaluation of Phase 1 Implementation of Interventions in the National Health Insurance (NHI) pilot districts in South Africa, Evaluation Report, Final. NDOH10/2017-2018; July 2019 [Cited 2019 November 28]. Available from: https://www.hst.org.za/publications/NonHST%20Publications/nhi_evaluation_report_final_14%2007%202019.pdf

15. Business Day. National Health Insurance Pilot projects reveal deep problems: Outreach teams didn't meet their target of improving infant health and care for pregnant women because there were not enough paediatricians and gynaecologists; 28 July 2019 [Cited 2019 November 28]. Available from: https://www.businesslive.co.za/bd/national/2019-07-28-nhi-pilot-projects-reveal-deep-problems/

16. The Conversation. South African taxpayers will bear the brunt of National Health Insurance; August 2019 [Cited 2019 November 28]. Available from:

https://theconversation.com/south-african-taxpayers-will-bear-the-brunt-of-national-health-insurance-122409

17. Fin24 News. Mini-Budget 2019. NHI Budget plans 'no longer affordable' – Treasury; October 2019 [cited 2019 November 28]. Available from: https://www.fin24.com/Budget/nhi-budget-plans-no-longer-affordable-treasury-20191030

18. BusinessTech. South Africa is facing a doctor shortage – here's why; October 2019 [cited 2019 November 28]. Available from: https://businesstech.co.za/news/government/346538/south-africa-is-a-facing-a-doctor-shortage-heres-why/

19. BusinessTech. Corruption costs SA GDP at least R 27 billion annually and 76 000 jobs; September 2017 [cited 2019 November 28]. Available from: https://businesstech.co.za/news/government/196116/corruption-costs-sa-gdp-at-least-r27-billion-annually-and-76-000-jobs/

20. Lewis, M. Governance and corruption in Public Health Care System. Centre of Global Development; January 2006. [Cited 2019 November 28]. Available from: http://www1.worldbank.org/publicsector/anticorrupt/Corruption%20WP_78.pdf

21. Mail & Guardian. Financial state of municipalities has worsened — AG; June 2019 [cited 2019 November 28]. Available from: https://mg.co.za/article/2019-06-26-financial-state-of-municipalities-has-worsened-ag

22. Financial Mail. Are South Africans taxed to the max? South Africans pay a lot of tax, but squeezing them further will hurt the country's international competitiveness; March 2019 [Cited 2019 November 28]. Available from: https://www.businesslive.co.za/fm/features/2019-03-14-are-south-africans-taxed-to-the-max/

23. Cardona, F. Guide to Good Governance No.03. Anti-corruption policies and agencies. Centre for Integrity in the Defence Sector. Norwegian Government Security and Services Organization. Published December 2015. [Cited 2019 November 28]. Available from: https://cids.no/wp-content/uploads/pdf/7250-DSS-Anti-corruption-GGG-3-skjerm.pdf

24. Specialised Anti-Corruption Institutions. Review of Models: Anti-corruption network for Eastern Europe and Central Asia. OECD; 2008. Available from: https://www.oecd.org/corruption/acn/39971975.pdf

25. NHS Counter Fraud Authority. Annual Report & Accounts. NHS fraud. Spot it. Report it. Together we stop it; 2017-18 [Cited 2019 November 28]. Available from: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/742458/nhs-counter-fraud-authority-annual-report-and-accounts-2017-2018.pdf

26. Thomson Reuters Practical Law. The NHS Counter Fraud Authority (Investigatory Powers and Other Miscellaneous Amendments) Order 2017 (SI 2017/960) comes into force on 1 November 2017. [Cited 2019 November 28]. Available from: https://uk.practicallaw.thomsonreuters.com/w-010-7773?transitionType=Default&contextData=(sc.Default)&firstPage=true&bhcp=1

27. Chetty J. An analysis of the Independence of the Special Investigating Unit as an anti-corruption agency in South Africa. Thesis (MPA). University of Stellenbosch, 2016. [Cited from 2019 November 28]. Available from: http://scholar.sun.ac.za/handle/10019.1/102157

28. Dullah Omar Institute for Constitutional Law. Legal Framework for SOE Boards. Towards transparency and quality in SOE board appointments. Cape Town: University of the Western Cape; [Cited 2019 November 28]. Available from: https://dullahomarinstitute.org.za/women-and-democracy/board-members-of-state-owned-enterprises-towards-transparent-appointments/reports/wandrag_legal_framework_v4-1-3-for-electronic-use-1.pdf/view

29. Ledger T, Rampedi M. Mind the Gap: Section 139 interventions in theory and in practise. Public Affairs Research Institute; September 2019 [Cited 2019 November 28]. Available from: https://47zhcvti0ul2ftip9rxo9fj9-wpengine.netdna-ssl.com/wp-content/uploads/2019/10/20191002_MindTheGap_Report_Ledger_Rampedi_v8.pdf

30. Government of Canada website [Cited 2019 November 28]. Available from:

https://www.canada.ca/en/health-canada/services/health-care-system/reports-publications/health-care-system/canada.html#a7

31. Reversing the trends, The second national health sector Strategic Plan of Kenya. Ministry of Public Health and Sanitation strategic plan 2008–2012. Published

December 2018 [Cited 2019 November 28]. Available from: https://www.uhc2030.org/fileadmin/uploads/ihp/Documents/Country_Pages/Kenya/Kenya%20ministy_of_public_health_and_sanitation_strategic_plan%202008-2012.pdf

32. Health Careers. Directors of public health hold some of the most pivotal strategic and leadership positions. NHS Health Education England [Cited 2019 November 28]. Available from: https://www.healthcareers.nhs.uk/explore-roles/public-health/roles-public-health/director-public-health

33. Mustard C. Revised by Shedden D. with advice from Regional Communicable Disease Officers and other First Nations and Inuit Health Branch (FNIHB) medical officers. January, 1997 / Ref.: cmmoh.3 [Cited 2019 November 28]. Available from: https://web.archive.org/web/20120101030321/http://www.hc-sc.gc.ca/fniah-spnia/pubs/finance/_agree-accord/initiative_transfer/index-eng.php

34. Republic of South Africa. Financial and Fiscal Commission. Division of Revenue Amendment Bill [B15-2019]: Repositioning Local Government Public Finances. Government Gazette No 42785; October 2019 [Cited 2019 November 28]. Available from: http://www.treasury.gov.za/legislation/bills/2019/[B15-2019]%20(Division%20of%20Revenue%20Amendment%20Bill).pdf

35. Okoroh J, Essoun S, Seddo A, Weissman JS, Dsane-Selby L, Riviello R. Evaluating the impact of the national health insurance scheme of Ghana on out of pocket expenditures: a systematic review; 2018. [Cited 2019 November 2019]. Available from: https://bmchealthservres.biomedcentral.com/articles/10.1186/s12913-018-3249-9

36. South African Broadcast Commission. State capture has cost South Africa over R500 billion [Cited 2019 November 28]. Available from: http://www.sabcnews.com/sabcnews/state-capture-inquiry-has-cost-over-r500-billion/

37. Scottish Health Council. What we do. [Cited 2019 November 28]. Available from: http://scottishhealthcouncil.org/about_us/what_we_do/what_we_do.aspx#.Xd-fhm5uLIV

38. Department of Home Affairs. Refugee Status & Asylum [Cited 2019 November 28]. Available from: http://www.dha.gov.za/index.php/refugee-status-asylum

39. News24. Fewer than 1 in 6 asylum seekers in SA granted refugee status; July 2019 [Cited 2019 November 28]. Available from:

https://www.news24.com/SouthAfrica/News/fewer-than-1-in-6-asylum-seekers-in-sa-granted-refugee-status-20190709

40. Department of Statistics South Africa. Mid-year population estimates [Cited 2019 November 28]. Available from: http://www.statssa.gov.za/?p=11341