COSATU

SUBMISSION ON THE NATIONAL HEALTH INSURANCE FOR SOUTH AFRICA: TOWARDS UNIVERSAL HEALTH COVERAGE

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1 INTRODUCTION

COSATU welcomes the release of the *National Health Insurance for South Africa, Towards Universal Health Coverage*, Version 40 (henceforth, the White Paper) for public comments. This provides us and the broader public with yet another opportunity to forge a broadest possible consensus on the future health system worthy of a democratic South Africa. Yet it is with regret and concern that we are only now drawing to a close the development of this final guiding policy statement since the overwhelming majority of the South African people first gave the African National Congress (ANC) a mandate on the National Health Insurance (NHI) in 2009.

We cannot emphasise enough the need for urgency and determination in the implementation of the NHI in the face of the massive burden of disease that afflicts our society. Indeed, ours is a society that has no option but to muster courage, to make resources available, to develop institutions and technical capacity and to mobilise the masses of the people to confront our four concurrent epidemics comprising poverty-related illnesses such as infectious diseases (including HIV/AIDS and TB), maternal and child deaths, non-communicable diseases and violence and injury.

We would like to remind everyone that health is a societal matter, and NHI is a constitutional commitment, and key to radical transformation.

As COSATU we pride and count ourselves amongst the torch-bearers in terms of the role that we have played over the years through our policy advocacy and mass-driven campaigns in advancing and defending the NHI and the course of the realisation of the right of access to health care services to all in line with section 27 of our Constitution. Indeed, as early as 1997 at its Policy Conference, COSATU called for "a national health care system" and "affordable medicines for all".[1] In 2000 our 7th Congress adopted a resolution that reaffirmed COSATU's commitment to fight for the NHI. In this regard, COSATU opposed the implementation of the Social Health Insurance (SHI) as this undermined the right of access to health care services to all in the absence of social solidarity and cross-subsidisation of the poor by the rich and the sick by the healthy.

2 OUR OVERALL POSTURE ON THE WHITE PAPER

In the overall, COSATU supports the broad thrust of the White Paper. Indeed, henceforth we expect that the debate that was fueled by the Treasury's idea (contained in the Green Paper) that an option of a multi-payer system must be

[1] Resolution on Broad Macro-Economic Framework and GEAR: COSATU Policy Conference, 1997.

explored is now closed especially within government, as it has unnecessarily consumed a lot time and caused confusion. Thus, we welcome the fact that the White Paper is broadly consistent with the resolution of our 12th Congress held in 2015, as it encapsulates a framework and objectives that begin to lay a foundation for a people's health system which is intended:

- To meet population's health needs.
- To remove financial barriers to health care.
- To reduce incidence of catastrophic health expenditures.
- To enable our country to meet national and international commitments and goals on health, and
- Ultimately to contribute to better quality of life, poverty alleviation and human development.

Thus, in this section we outline some of the key detailed policy propositions that we support, and where necessary we provide proposals to strengthen them. Thus, amongst others, we support:

- The NHI features, including the creation of a publicly administered single-fund, though we propose below that PHC must be included amongst the defining features of the NHI. Indeed, we support PHC re-engineering based on the four streams that are currently being implemented in the NHI Pilot Sites, namely:
    a. Municipal Ward-based Primary Health Care Outreach Teams (WBPHCOTs);
    b. Integrated School Health Programme;
    c. District Clinical Specialist Teams; and
    d. Contracting of private health practitioners at non-specialist level.
- The NHI principles, with our emphasis on the principle that health care is a public good and social investment.
- The universal scope of population coverage ranging from citizens, permanent residents and the so-called refugees. However, we propose that in conjunction with the Department of Home Affairs and the Department of International Relations and Cooperation, the existing policies and legislation pertaining to the rights of asylum-seekers and migrants as far as health is concerned must be urgently reviewed. Indeed, we propose that where necessary these must be replaced with those that would be consistent with the values and principles of our constitution and international commitments to prevent discrimination and to ensure compliance with the law by everyone on the South African land.
- The commitment to provide a comprehensive package of personal health services, although we call for proper engagement on the envisaged depth and service levels to ensure equal access to the same level of care for all whilst enforcing cost-containment measures and efficiencies.
- Abolishment of the Uniform Patient Fee Schedule and the exclusion of elective cosmetic surgery. The levying of fees to non-citizens at public hospitals must be

subject to and consistent with a new policy on asylum-seekers and migrants as proposed above.

- The opening of additional nursing colleges. However, we propose that there must be proper coordination with the Department of Higher Education to ensure seamless articulation with nursing education at university level.
- The increase of scholarships for health science students. However, this must not be in isolation but must be located within the broader thrust of moving towards free public university education.
- The proposed purchaser-provider split, a single-fund to leverage monopsony power through strategic purchasing of services and the proposed contracting arrangements to yield efficiency gains.
- The National Health Commission to harness a wide spectrum of available expertise and to facilitate broad-based consultation as well as Clinic Committees envisaged to harness popular experiences and grass-roots participation to build health awareness.
- The reassignment of the central hospitals to the national sphere of government.
- The building of capacity for the introduction of semi-autonomous management of central hospitals and the delegation of management autonomy at public hospitals level.
- The role of the Office of the Ombudsman as established within the ambit of the Health Professions Council of South Africa must be properly defined and aligned so as not to overlap with that of the statutory professional regulatory councils and the OHSC.

Our approach in this submission is to make our own contribution to help strengthen the design of the NHI. Therefore, this would include putting forward proposals on areas that we deem to be weak, providing a critique and alternative proposals on areas that we deem problematic and where necessary expressing our support on areas that we deem to be important towards the realization of Universal Health Coverage (UHC). Finally, consistent with our long tradition as a campaign-driven trade union movement, we conclude our submission by placing our key demands in this submission as we believe that they must be met in order to enhance the transformation of the health system.

3 THE CENTRALITY OF THE PRIMARY HEALTH CARE

The White Paper defines the NHI thus:

> "NHI is a health financing system that is designed to pool funds to provide universal access to quality, affordable personal health services for all South Africans based on their health needs, irrespective of their socio-economic status. NHI will be implemented through the creation of a single fund that is publicly financed and publicly administered. The health services covered by

> NHI will be provided free at the point of care. NHI will provide a mechanism for improving cross-subsidisation in the overall health system. Funding will be linked to an individual's ability-to-pay and benefits from health services will be in line with an individual's need for health care. Implementation of NHI is based on the need to address structural imbalances in the health system and to reduce the burden of disease."

The White Paper further says that:

> "Countries such as Brazil, Canada, Finland, Norway, Sweden, Thailand, Turkey and the United Kingdom have successfully implemented UHC systems. Access to health services and health outcomes in these countries has improved significantly taking them closer to UHC. Many countries that do not have UHC systems are actively pursuing this goal. Whether it is called 'Obamacare' (as in the USA) or 'Seguro-Populare' (as in Mexico) or 'National Health Insurance' (as in South Africa), the goal is the same: to ensure that the population has access to needed quality health services at an affordable cost. South Africa's approach towards achieving UHC will be through the implementation of NHI."

We accept that the definition ought to be succinct rather than long, though we believe that it also ought to be comprehensive in its succinctness. As suggested in the White Paper, whatever it is called (as different countries have their own versions), the key issue is that it is a policy geared at achieving UHC.

To date, the debate on the NHI in South Africa has been extremely polarised and often characterised by wilful distortions and fear-mongering on the part of those who are opposed to the NHI. Therefore, as COSATU we propose that the definition must encapsulate all the important features that distinguish the NHI that we seek to build. In its definition, the White Paper states that the NHI "is a health financing system" and goes on further to allude to some of the features, e.g. that it would be implemented through a single and publicly administered fund and that services are to be free at the point of care. However, as COSATU we believe that there is an important and distinguishing feature that is missing in this definition, i.e. the PHC approach. This is the foundation of the NHI and it is at the heart of its financial sustainability and success in relation to health outcomes. The emphasis on PHC distinguishes the NHI from any reform of health financing under conditions of a developing economy such as South Africa, and ours must be uniquely reflective of our specific conditions as inspired by:

- The African Claims, which called for "a drastic overhauling and re-organisation of the health services of the country with due emphasis on preventive medicine", with community based care services.
- The Freedom Charter, which envisaged a "preventative health scheme".
- Alma Ata Declaration, which stated that "primary health care is essential health care based on practical, scientifically sound and socially acceptable methods and

technology made universally accessible to individuals and families in the community through their full participation and at a cost that the community and country can afford to maintain at every stage of their development in the spirit of self-reliance and self-determination. It forms an integral part both of the country's health system, of which it is the central function and main focus, and of the overall social and economic development of the community. It is the first level of contact of individuals, the family and community with the national health system bringing health care as close as possible to where people live and work, and constitutes the first element of a continuing health care process".

We do appreciate that the White Paper fully embraces the primary health care approach. Nonetheless, we believe that it is absolutely essential that this approach must be a thread running throughout our own model of the NHI, including in the stated definition and features. This is particularly important not only because of the potential efficacy of the PHC, but also as a counter to the hospi-centric approach that characterises the private health system. The proponents of the private health system who want to maintain the status quo tend to use the current opaque and extortionate health costs in their argument against the NHI to claim that it can never be financially sustainable – as if it would be based on a hospi-centric model or on the prevailing costs structures imposed by the private providers. In the same vein, in emphasising this point, we would argue that the PHC approach must be part of the defining central features characterising the NHI as outlined in Chapter 2.

4 THE CENTRALITY OF PEOPLE IN BUILDING THE NHI

We support the identified building blocks of a viable health system as outlined by the World Health Organization (WHO), i.e.

1. Leadership/governance;
2. Health care financing;
3. Health workforce ;
4. Medical products and technologies;
5. Information and research; and
6. Service delivery

However, one major shortcoming in the White Paper is the fact that it fails to elaborate on some of these building blocks such as:

- On leadership in terms of what is required and entailed across different levels and domains.
- On health workforce in the context of the NHI as it relates to the current Human Resource Strategy for the Health Sector beyond mentioning that the WISN tool will be used.
- It also excludes an elaboration of the infrastructure plan to ensure the creation of a decent platform for service delivery.

Similarly, in our view missing amongst these building blocks are the people and their role in building and sustaining the health system. Health is both a personal and community responsibility, therefore it is critical that the NHI must recast endeavours pertaining to health promotion and disease prevention towards empowering individuals and communities to take active responsibility of their health and the health system as such rather than being passive recipients of information and services.

Whilst we welcome the fact that there is an emphasis on primary health care with its attended community-based promotion and preventative measures, for us the efforts to resolve the structural imbalances and problems outlined in Chapter 3 could be undermined and the NHI consequentially rendered financially unsustainable if the centrality of the people is not adequately appreciated and reconceptualised amongst the building blocks of the health system. The White Paper itself notes:

> "The increased prevalence of NCD's globally and in South Africa is contributing at least 33% to the burden of disease. Common risk factors for NCD's include tobacco use; physical inactivity; unhealthy diets, and excessive use of alcohol."

Furthermore, it says that:

> "Violence and injury also contribute significantly to the burden of disease. South Africa has an injury rate of 158 per 100 000. The most recent South African Burden of Disease data indicates that road traffic accidents and interpersonal violence are the leading causes of Years of Life Lost (YLL)."

Clearly the scale of the South African burden of disease is linked to the poor level of grassroots participation in building the health system and the limited knowledge on personal health in the communities. Often the community-based health programmes for promotion and prevention of diseases tend to be limited and reduced to be the remit of designated NGOs that are contracted to government and that are not always organically rooted in the communities in which they serve.

In addition, there is no awareness and popular participation in the establishment and work of the hospital boards. We would argue that in part, the poor attitude reflected by sections of the personnel in health facilities is engendered by the fact that there is a poor level of health education in the communities from which they come. This underscores the generalised alienation from the formal health institutions as often signified by their vandalisation. This alienation is also reflected in the problem of poor safety in health institutions for patients and health workers. Safety in our health institutions is reduced to the Neo-managerialist rationality that dominates planning and resourcing resulting in widespread outsourcing of the security function. Thus, the failure of this prevalent rationality of Neo-managerialism to appreciate a health institution as an organic and integrated system in which the core health care

functions are highly dependent even on some of the other functions that are considered mundane such cleaning, security, catering, gardening, etc. brings added problems arising from extremely exploitative outsourcing companies whose employees are alienated, powerless and dejected about the terms and conditions imposed in their contracts.

We therefore, propose that community participation and education should be recognised as central amongst the building blocks of our health system. This means that there is a need for the review of the manner in which health promotion and disease prevention programmes are carried out. This includes the review of health education in public education institutions and in society generally – in which the individual as part of a community takes full responsibility for their health and this must be placed at the heart of the different platforms of health education, including at the basic education level. At the same time, health must be located within the broader context of community development and related to other developmental social determinants of health.

Thus, the White Paper must go beyond the seemingly narrow bureaucratic definition of the roles of hospital boards that are supposed to "represent the views of the community" and exercise oversight on good governance, important as this may be. Board members must be active in the health campaigns that are carried out in the communities whose views they are expected to represent and their oversight responsibility must also be extended to site visits as a requirement. Hence, we welcome the thrust of the White Paper in proposing and defining the role of the Clinic Committees.

5 COMMUNITY HEALTH WORKERS: AS INTERGRAL AGENTS OF PHC

From the very beginning of the democratic South Africa, Community Health Workers (CHWs), who include home-based care givers, were recognised as indispensable in the envisaged transformation of the South African health system. Thus, when the ANC developed *A National Health Plan for South Africa* in 1994 it stated that:

> "Community Health Workers can play a unique role in promoting health and in expanding and improving health services provided they have effective support structures and referral systems and they receive ongoing training. They can also be catalysts for community development, mobilising people around health issues. Local programmes will be encouraged provided they are integrated into the local health services…"

In turn, in their emphasis on prevention, promotion and community participation as features of the health system, the African Claims, Freedom Charter and Alma Ata Declaration were also calling for a departure from the prevalent approach to PHC that relegates the role and contribution of CHWs to a peripheral and informal

domain. Instead, they called for the integral location of the CHWs in the health system.

COSATU welcomes the fact that the White Paper reaffirms the PHC as a critical component of the NHI as originally mooted in the Green Paper. Thus, as it constitutes the foundation of the health system, PHC reengineering and the attended effort to build of a strong District Health System is critical in the endeavour to re-orientate the South African health system away from presently dominant and financially unsustainable hospi-centric paradigm. This then underscores the indispensability of the cadre of the CHWs as it is upon their contribution that the success of the Municipal Ward-based Primary Health Care Outreach Teams (WBPHCOTs) in terms of their assigned scope of practice according the proposed PHC model would largely depend.

However, despite the appreciation of the indispensability of the CHWs to the success of the PHC, due to the prevalent Neoliberal rationality within government, in practice CHWs have been treated as mere informal extension to the public health system. Thus, virtually all the existing relevant policies which have been developed to date viz. the *National Guideline on Home-based Care/Community-based Care, December 2001*; the *Community Health Workers' Policy Framework, 2004* and the *National Human Resources for Health Planning Framework, 2006* have strayed away from the ANC's 1994 health plan which conceived the CHWs as agents to be "integrated into the local health services". In our view, underlying this is the dominant and overarching Neoliberal approach to fiscal policy dictated by the Treasury. Hence, the CHWs have been utilised via some non-governmental intermediaries that at worst have been little more than labour-brokers. This pertains to both their training and contracts, and it fits well within the Neoliberal logic that tends to be short-term in outlook - in its fixation with the thumb-sucked ratio of the "public service wage bill" to the budget, without appreciating the long-term human and indeed financial consequences of this on the health system.

The specification of the role and scope of practice of the CWHs in the White Paper, especially with regard to the WBPHCOTs implies that there is a lurking problem of the definition of CHWs whereby many of these workers may find themselves excluded. Currently it is estimated that there is an all-encompassing category of CHWs working in various areas of specialisation (each in one form or the other playing a significant role in PHC) that is approximately 72 000 strong in South Africa[2]. From our stand point, CHWs encapsulate a variety of primary health auxiliaries working in communities that include lay urban and rural health workers, community-based short-course (DOTS) supporters, HIV/AIDS communicators,

[2] Department of Health, 2011. CWH Audit Report. Tshwane: Department of Health.

home-based care workers, voluntary counselling & testing counsellors, peer educators and first aid workers. This might still include others.

In the context of the current dispensation that tends to vary nationally and often involving non-governmental intermediaries, the CHWs are faced with numerous difficulties as a group and as individuals. This includes high exposure to infectious diseases, crime, financial and employment uncertainty, poor provision of the necessary logistical supplies and resources, poor psychological support, substandard training programmes, lack of career-pathing beyond this level, etc. Our central concern in addition to all these difficulties that they face is their super-exploitation given the meagre stipends that they are currently given for their vital services. For example, CHWs in Gauteng are paid between R2500 and R4000 per month, yet the provincial department would still go out of its way to outsource the administration of the payment of its 9000 CHWs to a private company called Smart Purse Solutions Pty Ltd, to the tune of R87 million. This example and numerous others in different functional areas backs our argument that the persistent Neoliberalism that has been entrenched within government since GEAR is itself a threat to the financial sustainability of the NHI rather than what is usually deceptively put out as high public service wage bill.

If the current dispensation remains unchanged, as COSATU we can only caution that it must be expected that increasingly there would be spontaneous and widespread labour unrest, disruption of service delivery and therefore needless delay in the implementation process. In both instances where government directly and indirectly contracts the CHWs, its drive to externalise the costs and responsibility of employing them occurs at a severe toll and expense on the wellbeing of these workers. Necessarily, this includes gross violations of these workers' rights with regard to:

- The Labour Relations Act, which protects workers against unfair labour practices and unfair dismissals.
- The Basic Conditions of Employment Act, which protects workers against late payment or non-payment of wages, as well as provisions pertaining to working hours, overtime, leave, termination of employment, written terms of employment.
- The Employment Equity Act, which protects workers against unfair discrimination.
- The Skills Development Act, which provides for a career path through training.
- The Occupational Health and Safety Act, which provides for the health and safety of workers

These nationally varying contracting dispensations of the CHWs also go against the Code of Good Practice promulgated by the government itself which determines "Who is an Employee"[3], in terms of which CHWs can be deemed to be "employees" as

[3] Notice 1774. Government Gazette 29445, 1 December 2006.

they are covered by all the seven constitutive factors determining who an employee is.[4] In paying CHWs between R2500 and R4000 per month according to their various occupations, Gauteng is but one example of the existing contracting dispensations across provinces.[5] Equally, such variations also relate to the contracts entered into with non-governmental intermediaries that basically act as labour brokers between the workers and departments of health. If the *Community Health Workers' Policy Framework* of 2004 determined that the CHWs must be paid a minimum stipend of R1 000 (which was arguably not adequate then), even when allowing for inflation it is clear that this important cadre of PHC is grossly super-exploited at the moment.

In conjunction with France, South Africa is currently a co-chair of the United Nation's High Level Commission on Health Employment and Economic Growth, whose work is underpinned by the recognition of the need for decent jobs and that jobs in the health sector are not a cost but a social investment. This goes against the prevalent Neoliberal rationality that informs the South African government's attitude towards the compensation of the workers. Thus, as COSATU we make the following proposals:

1. CHWs must be employed by government as an integral part of the public service.
2. The determination of the terms and conditions of work must be brought for engagement at the Public Health and Social Development Sectoral Bargaining Council.
3. A mandatory training platform accredited by SAQA must be established by government. We have noted the curriculum that has been accredited by QCTO, which has commenced, but we are worried about the slow implementation. We believe there must be strong monitoring and evaluation of these process.

6 FINANCING THE NHI

6.1 The political economy of health

Chapter 7 of the White Paper deals with the financing of the NHI and so it is an important section since the NHI is defined basically as a "health financing system". Necessarily, the financing of the NHI would impinge upon some of the related structural features of the economy and society. Indeed, it also relates to the prevalent macroeconomic policies, specifically the fiscal and public finance management policies.

Table1: Key features of tax in SA and select countries

[4] Aids Law Project. Memorandum on Community Health Workers. 2008.
[5] We are aware that there is a Ministerial Determination Circular Number 1 of 2015 applicable related to the Expanded Public Works Programme.

Country	Income Tax Rate	Corporate Tax Rate	Tax as % of GDP	Government Expenditure as % of GDP
Croatia	40	20	30.4	47
Hungary	16	19	38.9	49.4
Argentina	35	35	30.6	40.3
Brazil	27.5	34	33.4	38.6
South Africa	**40.0**[6]	**28.0**	**24.7**[7]	**31.7**

Source: 2016 Index of Economic Freedom

Table 1 underscores the fact that conforming to certain "fundamentals", meaning some entrenched dogmatic Neoliberal ratios on the Income Tax Rate, Corporate Tax Rate, Tax as percentage of GDP, Government Expenditure as percentage of GDP, etc. prescribed by the Washington Consensus and doggedly supervised in countries such as South Africa by the sovereign rating agencies does not necessarily lead to higher economic growth rate or better economic management than in countries that pursue policies that respond to their own socioeconomic realities.

Based on some of the arguments that the Treasury tends to make in justifying its positions on economic policies, we might as well say that from its point of view, which is not dissimilar to those of the Heritage Foundation (the source of this data) whose concept of economic freedom is based on the idea of a small government that spends less socially, South Africa comes out positively and favourably in these data. This is despite the country's massive socioeconomic challenges and backlogs and yet with little to show in terms of the outcomes of the Treasury's conservative economic policies with regard to the triple challenges of unemployment, poverty and inequality.

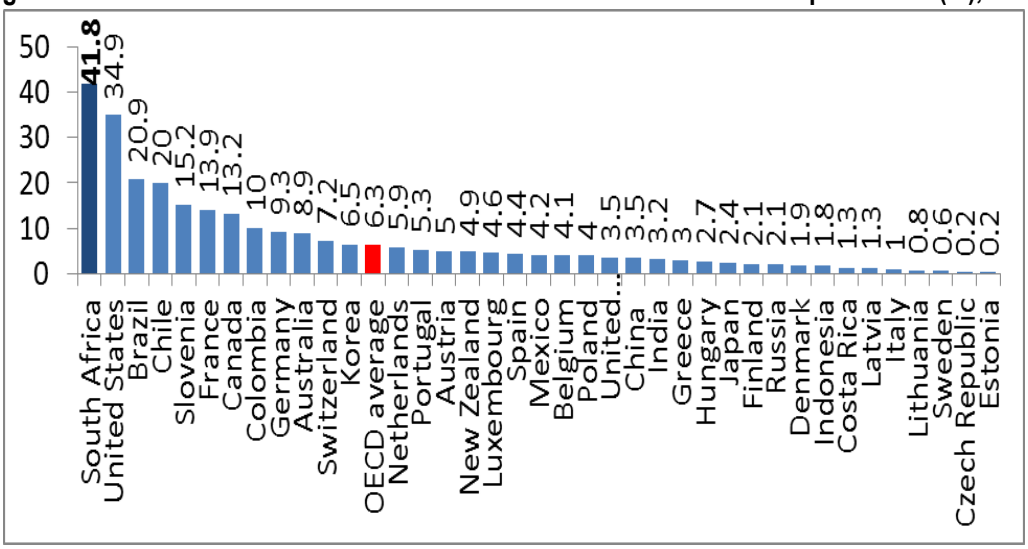
Currently the cost of private health care in South Africa is ranked amongst the most expensive in the world – comparable to the levels found across OECD countries and higher than what could be expected given the country's income.[8] In addition to the influence of the profit motive and the lack of transparency regarding the private health charges, there are also some fundamental structural features of this industry that must be addressed. This include the absence of any kind of a transparent mechanism of setting tariffs or charges, their concentration into four monopolies (since the late 1990s) which has given them an oligopolic power to freely impose tariffs on patients. The outcome of the 2004 Tribunal of the Competition Commission which resulted in the end of collective bargaining between these private hospital groups and medical aid schemes has made the situation worse. Thus, medical

[6] We are aware of the fact that since 2015/16 it has been raised to 41%.
[7] Actually in 2015/16 it is 26.3 per cent and it is intended to increase up to 27.8 per cent in 2018/19 according to the 2016 Budget.
[8] Lorenzoni, L. and T. Roubal (2016), "International Comparison of South African Private Price Levels", OECD Health Working Papers, No. 85 OECD Publishing Paris.

inflation has been consistently well above the average rate of inflation as confirmed in the study presented by the OECD and WHO to the Health Market Inquiry (HMI) under the auspices of the Competition Commission, which indicates that "between 2011 and 2013 private hospital prices grew faster than the average prices of goods and services purchased by households". [9] The same study states that South Africa spends a higher share of its total health expenditures on private voluntary health insurance (41.8%) than any country globally, as illustrated in figure 1. Indeed, the same applies with regard to the average profit rates raked in by these private health monopolies over an extended period, regardless of the business cycle.

This has resulted in workers and the broader middle-stratum who are members of the medical schemes seeing their benefits declining, the increase of co-payments and out-of-pocket payments. Some of these issues are described at some length in the White Paper although without an analytical framework of the political economy.

Figure 1: Private health insurance as a share of total of current health expenditures (%), 2013



Source: OECD Health Working Papers, No. 85.

When he launched the HMI in 2013, the Minister of Health, Dr Aaron Motsoaledi, said that "the artificially high private health-care costs need to come down as one of the two major conditions necessary for the successful implementation of the NHI". This basically means that the outcome of this inquiry is crucial in terms of the fate and sustainability of the NHI since the HMI is mandated to look at pricing in the private health sector with the view to reduce the current extremely high costs that may be caused by distortions or abuse of their oligopolic power. It is clear that unless private health costs are substantially reduced, the NHI would not be implementable or sustainable. It is therefore disappointing that the White Paper merely describes this problem without pointing to what needs to be done with regard to the oligopolic power of these companies and the lack of competition amongst them.

[9] Ibid.

However, what is even more disturbing in the ongoing process of the HMI is the so-called Revised Terms of Reference produced this year by its panel. Despite clear evidence indicating that private medical costs began to spiral out of control after the concentration of private health providers[10], the HMI is ruling out any option geared at the restructuring or the breakup of this oligopoly. Worse yet, in its Revised Terms of Reference, HMI broaches the Social Health Insurance model, a recommendation that runs counter to the purposes for which it was established and indeed that is beyond its mandate. In the same vein, as COSATU we are concerned that provincial governments continue to approve applications for the construction of private hospitals even where they are not needed as profit-seeking investors expect to rake in huge margins based on the current trajectory.

Table 2: Government revenue and spending on health lower and middle income countries[11]

	Lower-middle income countries	**Upper-middle income countries**
Govt revenue as a % of GDP	30.6	32.7
Total health spending as % of GDP	6.6	7.1
Govt health spending as % of total health spending	63.5	61.8
Govt health spending as a % of general govt spending	12.1	11.5
Number of countries	55	47

Source: World Health Organisation, 2008.

This bring us back to our critique of the guiding and operational Neoliberal rationality of the Treasury that tends to justify inequality and deprivation, whilst (in this case) trying to pursue an essentially redistributive programme in the form of the NHI - that is based on equitable contribution and social solidarity. To a great extent, spending patterns by countries reflect the manner in which health is prioritised. According to the World Bank, the share of total government expenditure allocated to health across 157 countries is around 11.5 percent as indicated in table 2.[12] In this regard, South Africa compares poorly and unfavourably despite its heavy burden of disease. Thus, in terms the preferred option in the White Paper which envisages NHI expenditure to increase by 6.7% in real terms from 2015/26 up to 2025/26, in which public health spending would rise "from around 4 per cent of GDP currently to 6.2 per cent of GDP by 2025/26, assuming the economy grows at an annual rate of 3.5 per cent", this would still be far below the international average in terms of public health spending in

[10] From a presentation by the Minister of Health, Dr Aaron Motsoaledi to COSATU on the 10th November 2015.
[11] Extracted from a table in Cheryl Cashin. A World Bank Study: Health Financing Policy. The Macroeconomic, Fiscal and Public Finance Context. 2016.
[12] World Bank. 2015. World Development Indicators. Washington D.C.

comparison to the 47 upper-middle income countries as captured in the World Bank's study in table 2.

So, whilst on its own adding more funds is not a panacea to addressing the massive burden of disease such as South Africa faces, it nonetheless remains an indispensable and key enabler in pursuit of the public health objectives. Therefore as COSATU we believe that South Africa can still do more in terms of increasing the share of health in government spending. In the same way, we concur with the WHO when it states that "economic growth alone is often not sufficient to bring about adequate increases in real government health spending to achieve health sector objectives".[13] Hence, we remain concern as to the implications of the assertion made by the Treasury when it tabled the 2015 Budget that the implementation of the NHI depends on economic growth. The fact that in the 2016 Budget the NHI is only allocated R4.5 billion over the next three years, that only the information system to improve patients' records is receiving additional funds and the Health Facilities Revitalisation Grant has been reduced by R365 million over the medium term is a major concern in the light of the projected public health spending in the White Paper. Similarly, whilst we note that the critical posts such as nurses and doctors will not be "blocked on government's payroll system" as stated in the 2016 Budget Review, it is unclear as to what this means with regard to the vacancies in hospitals at the level of administrative staff, potters, gardeners and others. Equally, we are concerned as to what the implications of this in terms of the employment or absorption of the CHWs and home-based care workers as part of building the PHC.

6.2 Proposals on the financing of the NHI

The White Paper purports to be guided by the recommended approach of the WHO, according to which "it is not useful to focus on getting the exact number indicating the estimated costs."[14] And so, since the WHO advises that "it is better to frame the question around the implications of different scenarios for implementing reforms towards achieving UHC", the White Paper sets out five alternative scenarios, though at the same time it proceeds to put forward the "preferred option". In this preferred option, which is a projection based on the 2010 prices, between 2015/16 and 2025/26 financial years, the NHI expenditure grows by 6.7% on an annual basis to a total funding requirement of R255 815 billion. Yet according to the White Paper (Table 2) in total South Africa has already exceeded this amount as it spent R263 579 billion (8.6% of GDP) on health in 2013/14, incorporating spending in the private health sector that includes funds from medical aid schemes that are subsidised by the state. The subsidisation of public servants and other employees in the public

[13] Kutzin, J., C. Cashin, and M. Jakab. 2010. Implementing Health Financing Reforms: Lessons from Countries in Transition. World Health Organisation on behalf of European Observatory on Health Systems and Policies.
[14] WHO (2015) Costing health care reforms to move towards Universal Health Coverage (UHC): Considerations for National Health Insurance in South Africa. Geneva: World Health Organization.

sector as such by the state for use in the private health sector is but one of the paradoxes of the current health system.

Given the fact that within this preferred option there would be 6.7% annual growth in health spending up to 2025/26 amidst the expanding coverage and deepening quality of care, this then means that it is expected that there would be large scale efficiency gains in the implementation process in terms of this preferred option. However, from our point of view this raises the following issues of concern:

1. Based on this preferred option, we have to assume that there would be significant efficiency gains and effective cost–containment measures implemented even though in this chapter this is mentioned only in passing. Thus, it is a concern that whilst the White Paper is already setting out a preferred option and placing a target number (R256 billion), it does not explicitly elaborate or even quantify such efficiency gains as part of clarifying the rationale of this option. The World Bank itself suggests to countries that in reforming health system to achieve UHC, governments must do so with "realistic costs estimates, address and quantify potential efficiency improvements".[15] This would have been helpful since it already represents a major reduction in health spending - for example when combined public and private health spending in 2013/14 (R310, 536) is compared to the 2025/26 NHI expenditure (R255 815).

2. It is stated by the White Paper that "the projections set out in the Green Paper were derived from a model of aggregate costs built on projected utilisation based on demographic trends." Accordingly, in this White Paper this has been revised "based on more recent estimates of the costs of the NHI pilots and other reforms currently being implemented." To the extent that the Green Paper entertained the need to explore a multi-payer model, this raises a question as to the design basis of these aggregate costs when the private health providers continue to keep the actual costs for service in secrecy. This seems to go against the advice of the WHO which states that "costing studies can be very helpful – but only if they reveal information on the underlying cost structure of service delivery…".[16] Indeed, even with "the costs of the NHI pilots and other reforms currently being implemented" being taken into account, which is a limited period of time and scope of reforms anyway, a question arises as to whether these projections are based on the characteristic input-based line-item budgeting in the public sector and the prevailing pricing and fee-for-service payment arrangements in the private sector.

[15] C, Cashin. (2016). Health Financing Policy: The Macroeconomic, Fiscal, and Public Finance Context. Washington D.C.: The World Bank.
[16] Ibid.

We now come to our own proposals on the sources for financing of the NHI. We have previously[17] proposed that the "the state will finance health care under NHI through three mechanisms (a) general revenue, which will provide bulk of funding, (b) mandatory progressive contribution for anyone who pays personal income tax; and (c) payroll tax from employers." We maintain this position - thus we see these as a mix of the primary sources to finance the NHI but they would have to be complemented by other revenue raising options as proposed below.

6.2.1 General national revenue

From Table 1 in this submission which compares South Africa against a select number of countries that are in a more or less the same economic bracket, it is clear that when it comes to Government Expenditure as a percentage of GDP, South Africa comes out poorly. This is directly related to the tax policy, which the Treasury often claims that it is progressive when in fact it is based on a corporate tax rate that is very low for an underdeveloped and extremely unequal society. Hence, the proportions of revenue and government spending when measured against the size of the economy are very low. In part this is because when the economy experiences a recession or when growth decelerates; the Treasury tends to resort to the stock Neoliberal tools such as tax cuts and youth wage subsidy, whose positive effects on economic performance are yet to be illustrated. Thus, overtime the size of the revenue virtually remains constricted or stagnant as a proportion of GDP.

Since we as COSATU envisage the general national revenue to continue to play a key role in the financing of the NHI, we propose that other tax measures to enhance and complement the national revenue must be put in place. There is no doubt that economic growth is critical to the increase in the general revenue, especially in the light of the supposedly competing and pressing spending pressures. However, in a case such as South Africa, the tax net must be expanded even in the midst of a subdued economic performance. Indeed, since there is a need to expand the national revenue to respond to these spending pressures, as COSATU we propose that there are some other tax measures that must be considered. In line with the resolution of the COSATU Central Executive Committee (23-25 May 2016) we call for the exploration and the implementation of a wealth tax. The White Paper cites small amounts of revenue from the Securities Transfer Tax and Estate Duty (which it regards as a form of a wealth tax) to imply that these are not viable sources of funds when it should be proposing how they could be reviewed to ensure that they enhance national revenue or a complementary sources to fund the NHI. Indeed, as

6.2.2 Payroll tax

[17] NEHAWU Submission on Government Notice, Gazette No 34523. National Health Act (61/3003): National Health Insurance in South Africa Policy Paper.

The current social security insurance arrangements, i.e. retirement and health insurances evolved out of the Apartheid social security system, which was based on the expectation that everyone would be employed, hence the beneficiaries were generally white. Thus, in this voluntary arrangement the state provided tax expenditure subsidies to incentivise enrolment of employers and employees. The NHI requires mandatory enrolment and mandatory pre-payment arrangement. Thus, along the lines of the reforms introduced in 1998 in the France, as COSATU we propose that there must be a payroll tax levied on employers. There would have to be a detail consideration as to what kinds of categories of small businesses that can be excluded in this regard. As acknowledged by the White Paper that "the present payroll burden is low" and since many employers are already contributing to their employees' premiums, a shift to a payroll tax in this regard should impose no "distortionary" effect on the labour market. In any event, we believe that it is in the interest of employers to invest in the health of the labour force to enhance productivity.

6.2.3 A surcharge on taxable income or NHI tax

Along the lines of the French General Social Contribution, we propose the introduction of a progressive earmarked tax levied not only on wage (above a determined threshold) but also on income from financial assets and investments. This mandatory progressive contribution for anyone who pays personal income tax must be based on a sliding scale to ensure equitable contribution and social solidarity. Thus, we believe that this form of NHI tax has the benefit of being more broad-based as it would incorporate many of the employees who currently have no health insurance arrangements with their employers, wealthy individuals who are neither employees nor employers and some of the self-employed who would be levied in proportion to their ability to contribute.

6.2.4 On Value Added Tax

As COSATU we do appreciate that in formulating measures intended to constitute the mix of the sources to finance the NHI, to some extent there has to be some balance amongst the range of the chosen tax instruments. However, in this White Paper the drift of the arguments presented seems to foreground the VAT. We reject the inclusion of VAT as an option out-rightly. In the first instance, despite the White Paper's ambiguity on its negative effects, VAT is characteristically regressive and this goes against a key principle of equity as set out in section 7.2.2 that deals with the principle of tax design. The fact that the Treasury imposes extra tax on alcohol and tobacco products purportedly to discourage their consumption is a recognition of the negative impact of such indirect taxes on household spending, which becomes a serious issue of equity and social justice when applied across (excluding the narrow list of zero-rated items), as it may cause deprivation and hunger. This is the distortionary effect that is not given equal weight as given to the direct taxes on income that allegedly may affect productive economic activity.

6.2.5 On Tax Credits

In addition, the White Paper states that “the special character of health expenditure is taken into account in the design of personal income tax, which provides relief for medical scheme membership contributions and for health expenses that exceed prescribed threshold of income. Recent reforms of these provisions have made the relief more equitable”. In this regard, it seems as if the White Paper seeks to justify these tax credits, thus missing the point that in a non-mandatory environment this occurs in favour of a targeted section of the population to the exclusion of the overwhelming majority who are unable to enjoy the level of health care that this discriminatory credits facilitates. The White Paper must explicitly state that these rebates would be phased out rather than merely stating that “as the NHI evolves, the tax treatment of medical expenses and medical scheme contributions will be reviewed” or even worse that they would be phased out only “once the NHI is fully operational”. COSATU is opposed to this proposal and we propose that these tax credits must be phased out as soon the legislation introducing mandatory contributions is enacted.

6.2.6 On retirement insurance and medical benefits in other funds

It is logical and as COSATU we support the White Paper when it states that “NHI coverage will also include medical benefits currently reimbursed through the Compensation Fund for Occupational Diseases and Injury (COIDA), Compensation Commissioner for Occupational Diseases in Mines and Works Act (ODMWA), Unemployment Insurance Fund (UIF) and the Roads Accident Fund (RAF)”. However, we believe that the ongoing implementation process should determine the phasing in process of these funds, rather than stating that only once the NHI has been fully implemented.

To date, the Treasury has not released the discussion paper on Comprehensive Social Security Reform. Only this year, during the Budget Speech after COSATU declared its intension to embark on an indefinite general strike, did the Treasury undertake to release this document at some undetermined date in the course of the year. The engagement at NEDLAC on this discussion paper must address how the funds related to the post-retirement health insurance embedded in retirement schemes are going to be integrated to the NHI.

7 THE NHI INSTITUTIONS AND THE PHASED IMPLEMENTATION PROCESS

The White Paper states that that amongst others, the Office of Health Standards Compliance, District Health Management Office and National Health Commission shall be established in the first phase, meaning by the end of next year. Then a fully functional NHI Fund shall be established in the third phase. COSATU would like to see uninterrupted implementation of the NHI and the establishment of its institutions

in line with the plan and its phases. However, we can only hope that the DOH would improve its capacity to establish these institutions as the experience since the promulgation of legislation establishing the OHSC is a concern. The OHSC has been unable to enforce compliance by health institutions due to delays in the promulgations of regulation and the lack of legal capacity or to undertake inspections in keeping with its target due to the lack of resources and personnel.

Thus, whilst the NHI Fund is planned to be fully functional during the last phase of the implementation process, it is clear from its required capacity and resources that unless the department proactively plans ahead and begin the process of implementation appropriately, even more serious delays would be encountered, which would undermine the credibility of the NHI. The establishment of Fund and its accompanying public entity, with its specialised technical skills, would require adequate time for such capacity to be built and fully functional.

COSATU strongly recommends that NHI embrace the role of the South African Health Products Authority (SAHPRA) to ensure quality control and monitoring of medicines and other medical devises linked to the Essential Drug List (EDL) and Essential Equipment List (EEL) – "The objects of SAHPRA are to provide for the monitoring, evaluation, regulation, investigation, inspection, registration and control of medicines, schedule substance, clinical trials, and medical devices, IVDs and related matters in the public interest. We therefore propose that SAHPRA as an institution should be properly located in the NHI paper, as support institute for the fund".

7 CONCLUSIONS

We conclude our submission by reiterating our demands and proposals which must be met and we believe that addressing these demands can go a long way in strengthening the design of the NHI and laying a foundation of a genuine people's health system:

1. An end to the current public-private-partnerships arrangements in the building and management of hospitals and clinics, as exemplified by the Universitas, Pelonomi, Chief Albert Luthuli Central hospitals, etc. This includes the use of ppps in the furbishment or rebuilding of the so-called "6 Flagship hospitals", i.e. King Edward VIII (KZN), Dr Mukhari (Gauteng), Nelson Mandela (E Cape), Chris Hani Baragwaneth (Gauteng), Polokwane (Limpopo) and Nelspruit Tertiary (Mpumalanga).
2. The Public Investment Corporation must immediately stop using the retirement savings of public service workers to invest in projects that are geared at the construction of the for-profit private hospitals and clinics.
3. An increase in public health spending as a percent of GDP in line with the requirements of the implementation of the NHI and a stop to the Treasury's

austerity measures that are threatening to close permanently the unfilled vacancies.

4. Taking into account the judgement of the Constitutional Court handed down last year on the proclamation of the President to effect sections of the National Health Act pertaining to the Certificate of Need, we call on government to act urgently to put in place mechanism to address applications in order to stem the tide of reckless and profit-driven issuing of new licenses for private hospitals and clinics.
4. The absorption of CHWs into the public service, engagement on their terms and conditions of work at the Public Health and Social Development Sectoral Bargaining Council and the establishment of a mandatory training platform accredited by SAQA.
5. Engagement at the PSCBC with the department on what the Treasury in the 2016 Budget calls the “revised human resource plans” to ensure that it is consistent with the human resource requirement of the NHI and that all existing vacancies in public health are filled, including all the supportive functions of care services in health institutions, such as the administrative staff, gardeners, potters, cleaners and others.
6. And end to the outsourcing of functions in health institutions and public agencies, including cleaning, laundry, maintenance, ambulance services, catering, security, administration and others.
7. The Department of Health must move with speed in appointing PHC facility managers and in reviewing the occupational specific dispensation (OSD) to cover managers of PHC facilities.
8. The further elaboration of the NHI in the work-streams established by the DOH does not have undue influence of powerful countries that are seeking to leverage their funding of certain health programmes to derail the implementation of the NHI in terms of the mandate received by the ANC in 2009 and 2014.
9. The introduction of Workload Indicators of Staffing Need (WISN) must be exclusively geared at improvement of the quality of service delivery, it should be confined at hospital level and implemented in a manner that is in conformity with the relevant labour laws and ongoing consultation with representative trade unions.

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