National Health Insurance Bill

Public Submission of the Democratic Alliance

25 November 2019

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1. Introduction

Since the dawn of democracy, the National Health Insurance Bill is undoubtedly one of the most consequential pieces of legislation to be tabled in Parliament. The Bill is laudable insofar it aims to progressively realise section 27 of the Constitution of the Republic of South Africa.

As the Democratic Alliance (DA), we realise the gross inequalities in our health sector. Only 16% of SA citizens are covered by medical insurance and are thus dependent on the private sector, whilst the remaining 84% depend on the public health system.

Over the past 25 years there has been systemic failures of the health system. Below are the key diagnostic elements:

- There has been no systemic overhaul of health in the country to take into account the growing demand of an expanding population and its increasing reliance on the public health system;
- There has been little innovation in this industry by the South African government and very limited public/ private partnerships to ease the burden on the state system. This can be demonstrated by the lack of focus on preventative health measures in order to move away from a curative approach to health;
- There has been a growing distrust of the private health industry which has allowed little cooperation and partnership;
- There has been a tendency to 'throw money at the problem'. The public health system spends over R222 billion on healthcare, one of the highest GDP allocations in the world with very poor health outcomes to show for it;
- There has been no accountability for political leadership in our country. It has been revealed that over R20 billion has been lost to corruption in the health sector per year. This signals that the public health industry has serial offenders who are never dismissed and charged for their crimes;
- The Health industry, like other parts of our country, is deeply unequal and does serve the people as it should.
- While there is a global demand to move towards Universal Health Care (UHC) as per the World Health Organisation guidelines and our Constitution, the neglected parts of the system are not yet rectified.
- This legislation focuses on the funding for healthcare and does not in any way seek to fix was is truly broken.

To truly illustrate this point, a report on the public health sector tabled in Parliament in 2018 revealed that a vast majority of clinics and hospitals are all operating far below the required standard. Following inspections by the Office of Health Standards (OHS) in 2016/17, only five out of 696 public health facilities managed comply with the norms and standards set by the Department of Health and the 80% "pass mark" set by the Department. Public healthcare Institutions have suffered from a culture of corruption and incompetence which has led to poor management, underfunding, understaffing, a loss of skilled staff and deteriorating infrastructure.

As the official opposition of the country, it is incumbent on the DA to propose alternatives to the National Health Insurance Bill. The goal of UHC cannot be achieved through the NHI and indeed, the legislation is not the only way in which we can get there.

The DA is committed to ensuring that there is a quality health system for all South Africans, and it is funded efficiently with the requisite accountability measures in place.

That is why we have proposed the Sizani Universal Healthcare Plan which would seek to rollout UHC within the next 5 to 8 years and ensure that all those who are reliant on both the public and the private health systems are protected and catered for.

2. Why this submission?

The National Health Insurance Bill was introduced in the National Assembly on 08 August 2019 and referred to the Portfolio Committee on Health. The Democratic Alliance (DA) has three members sitting on this Committee, all three whom are very active in the Parliamentary process.

As members of Parliament, Siviwe Gwarube, Lindy Wilson and Haseena Ismail will actively contribute to and vigorously oppose the NHI Bill when the Bill is comprehensively discussed in Committee.

The DA has, however, taken an unprecedented decision to also submit our comments, objections and suggestions for improvement during the public comment process. We launched an online petition that has thus far garnered the support of more than 80 000 South Africans. Ordinary citizens from all walks of life were encouraged to sign the petition and give comments, whilst still sending official comments through the Parliamentary channels.

Our presentation essentially encapsulates the concerns of these tens of thousands of South Africans. On several occasions, we have seen Parliament being turned into a rubber-stamping institution where the valid concerns of voters from opposition parties are merely ignored. We have legitimate concerns that the same will happen with the National Health Insurance Bill and therefore we, as the official opposition, make this submission on behalf of the people of South Africa.

3. Comments on the Bill

Essentially, there are **25 key reasons why South Africans do not support** the NHI Bill. All of our reasons are derived from and substantiated by submissions from ordinary citizens.

The 25 key reasons are:

1. It is unclear what services or package of care will be included under NHI system.
2. SEO'S are failing and as an SOE NHI fund will be very vulnerable to mismanagement and corruption
3. The referral pathways are too strict and adherence to these will be difficult for ordinary people
4. The Bill imposes conditions on which treatment can be refused and obtaining a second opinion or seeking alternative forms of treatment will be nearly impossible
5. There are ethical concerns in what and how healthcare providers can treat patients
6. There is a clear erosion of provincial powers
7. The health system will be fragmented where certain spheres will be under local, provincial and national government management. This will do nothing to create synergy in the health system and will make accountability to citizens difficult if not impossible.
8. The Bill completely removes the choice for South Africans to choose where to get their healthcare
9. South Africans will have to contend with an additional personal tax burden.
10. NHI is unaffordable as it stands and is fiscally unaffordable as has been confirmed by Treasury. The South African economy is on its knees due to reckless spending, corruption and lack of accountability already.
11. The Bill invests unvetted powers to the Minister of Health.
12. There are no reasonable accountability measures as the corruption Investigating Unit is situated within the Fund which is effectively managed by the Minister.
13. There is no clarity on the composition of Investigating Unit
14. There is no clear feedback mechanisms to complaints
15. Insufficient or unclear process in establishment and functioning of Appeals Tribunal
16. Several concerns relating to eligibility of board members
17. The Minister can appoint his or her own representative as chairperson
18. There's little guidance on quorums and deadlocks of the Board
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20. Medical aids will cease to exist
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22. The Bill presumes the Act will be applied retrospectively
23. Implementation of NHI will likely lead to a brain-drain of critical skills in the country
24. There are concerns about the Constitutionality of the Bill
25. Government does not have the capability to properly manage procurement processes. The failed NHI pilot projects demonstrated how poor the department was in remunerating healthcare practitioners under this system.

The establishment of The National Health Insurance Fund as a public entity

1. It is unclear what services or package of care will be included under NHI system

Section 25 deals with the establishment of the Benefits Advisory Committee. In terms of section 25(5) this committee will be responsible for determining and reviewing the health care service benefits and types of services to be reimbursed at primary health care facilities, detailed and cost-effective treatment guidelines and the health service benefits to be provided by the Fund in consultation with the Minister.

Besides the above-mentioned reference, South Africans are expected to comment on the NHI Bill when we don't even have a basic idea of what will be covered under NHI. It is our submission that it is unfair to expect citizens to comment if the Department can't provide an idea of what services and medications will be included and excluded respectively.

2. SEO'S are failing and as an SOE, NHI fund will be very vulnerable to mismanagement and corruption

We need a capable State which possesses the capacity, the political stability and the general ability to deliver universal health care to the citizens of South Africa. Given the current state of our economy and especially our State-run Enterprises (such as Eskom, Denel and the SABC), it is common knowledge that the Government will not be able to effectively establish and maintain such a large scale undertaking.

The Bill explicitly states that the fund will operate as a public entity which will be constituted by the pooling of funds both from the public and private sector. The Minister has sole discretionary powers over this fund. It is our submission that This fund will serve as just another SOE vulnerable to grand corruption at the expense of the nation's entire health system.

Health coverage concerns

3. The referral pathways are too strict and adherence to these will be difficult for ordinary people

Section 7(2)(d) compels users of the Fund to access health care services at a primary health care level as the entry into the health system. They are also compelled to adhere to the referral pathways as prescribed and will forfeit health care services purchased by the Fund if they fail to these prescribed pathways.

It may be argued that these referral pathways are also an unnecessary and burdensome provision, which may lead to users being unreasonably excluded from being covered by the Fund. For example, what would happen to a pregnant woman who decides to skip the general practioner (the primary care provider) and go straight to her regular gynaecologist or obstetrician?

This places unnecessary pressure on the health system and can lead to additional costs, especially in cases where a visit to the general practitioner could have been avoided.

4. The Bill imposes conditions on which treatment can be refused and obtaining a second opinion or seeking alternative forms of treatment will be nearly impossible

Section 7(4) sets out circumstances in which funding for treatment may be refused. In terms of this section, treatment must not be funded where a health care service provider demonstrates that:

- *no medical necessity exists for the health care service in question;*
- *no cost-effective intervention exists for the health care service as determined by a health technology assessment; or*
- *the health care product or treatment is not included in the Formulary, except in circumstances where a complementary list has been approved by the Minister.*

It must be submitted that it may be necessary that the element of reasonableness be included in the circumstances where funding of treatment may be refused. To this effect, it can be proposed that the provision be formulated in the following manner: "Treatment must not be funded if a health care service provider reasonably demonstrates that— […]".

This would ensure that the funding for treatment is not refused on unreasonable grounds. Although it may be argued that the element of reasonableness is implicit in the execution of legislation generally, it is imperative that this element be included from the inception of the Bill. Failure to do so may lead to unnecessary litigation, which in this case may be a death sentence.

Another point on which clarity must be sought, is whether the Bill will allow for users of the Fund to approach more than one primary healthcare service provider in instances where they would like a second opinion. If the Fund does not make provision for users to be covered for further opinions from other health care service providers, it may undeservedly impact on those users' right to access to health care.

Section 7(5) determines that the Fund provide users with certain particulars in the event that treatment is not funded. This includes providing the user with a notice of the refusal; reasonable opportunity to make representations in respect of such a refusal and the provision of adequate reasons for the decision to refuse the health care service to the user. In terms of section 7(5)(c), the Fund is also compelled to consider representations made by users in relation of a refusal.

A question in this regard, is the issue of emergency or critical medical situations. Not treating certain conditions in timeous manner can have severe medical consequences. If, for example, a patient complaining of symptoms relating to his or her eyes and treatment is refused, that patient might go blind whilst trying to reverse the decision of the fund.

5. There are ethical concerns in what and how healthcare providers can treat patients

Section 39(2)(iii) states that a health care provider must adhere to "treatment protocols and guidelines, including prescribing medicines and procuring health products from the

Formulary". This can limit a provider's agency in treating a patient and has ethical implications for doctor's and other providers. For instance, what would happen if a doctor thinks treatment *x* is better for a specific condition, but the Formulary states treatment *y* must be given?

Nationalisation of healthcare

6. There is a clear erosion of provincial powers

Section 7(2)(f) affords the Minister of Health the power to designate certain central hospitals as national government components. The administration, management, budgeting and governance of central hospitals will be a competence of national government. The management of these hospitals will be semi-autonomous as the national government will have certain decision-making powers, including control over financial management, human resource management, minor infrastructure, technology, planning and full revenue retention.

We argue that the Bill completely centralises the provision of healthcare by placing the management of all central hospitals under the national department. This is, in our view, is the undermining of provincial powers as enshrined in the National Healthcare Act of 2003. In practice, the equitable share of funds to provincial departments will directly finance the fund, meaning poorer health outcomes for ordinary South Africans. Provincial departments are already stretched in terms of the healthcare services they are required to rollout, and a reduction in their equitable share will be disastrous for the actual delivery of healthcare. Provinces are at the coalface of the delivery of health services and must be given more funds to improve public health care, not less.

7. The health system will be fragmented where certain spheres will be under local, provincial and national government management. This will do nothing to create synergy in the health system and will make accountability to citizens difficult if not impossible

Currently, the health system is premised on an all-encompassing referral system, from community health workers who form part of the primary health system right through to tertiary hospitals. The Bill seeks to change this by having tertiary hospitals under the management of the national department. This will lead to a complete breakdown in the system, and ordinary South Africans will not be able to hold provincial departments to account for poor outcomes.

Fragmenting the health system will bring normal functioning systems to a grinding halt, and take power and decision making further away from people, not closer to them.

8. The Bill completely removes the choice for South Africans to choose where to get their healthcare

This Bill removes the autonomy of South Africans to choose their own healthcare. It mandates the national Department of health as the sole provider of healthcare in the

country while all private healthcare providers will be contracted by the state. This means that there is absolutely no choice for people on which services to purchase, nor will there ever be competition to drive up the quality of healthcare.

Funding of the Bill

9. South Africans will have to contend with an additional personal tax burden

Section 49(1) provides that the Fund is entitled to money appropriated annually by Parliament in order to achieve the purpose of the Act. Such money, in terms of section 49(2), must be appropriated from money collected and in accordance with social solidarity in respect of:

a) general tax revenue, including the shifting funds from the provincial equitable share and conditional grants into the Fund;

b) reallocation of funding for medical scheme tax credits paid to various medical schemes towards the funding of National Health Insurance;

c) payroll tax (employer and employee); and

d) surcharge on personal income tax, introduced through a money Bill by the Minister of Finance and earmarked for use by the Fund, subject to section 57

Such money must be calculated in accordance with the estimates of income and expenditure as contemplated in section 53 of the Public Finance Management Act.

The financing model of this Bill will mean the removal of the tax credit benefit afforded to medical aid clients while imposing a new tax on ordinary South Africans to fund this new SOE. Our submission is that ordinary South Africans have been squeezed dry by government taxes and cannot be subjected to yet another tax.

10. NHI is unaffordable as it stands and is fiscally unaffordable as has been confirmed by Treasury. The South African economy is on its knees due to reckless spending, corruption and lack of accountability already

Treasury has said that government's original estimates for implementing National Health Insurance are simply unaffordable in the current fiscal environment, and even a limited package of reforms will require an extra R33 billion on top of the existing health budget from 2025/26.

In his medium-term budget policy statement (MTBPS) in October, Finance Minister Tito Mboweni clearly outlined the unaffordability of NHI:

Originally, NHI costs were projected to increase public health spending from about 4% to 6% of GDP over 15 years. However, given the macroeconomic and fiscal outlook, the estimates to roll out NHI that were published in the NHI Green Paper in 2011 and in the White Paper in 2017 are no longer affordable.

Many respectable economists have warned that NHI will hurt our already ailing economy and increase our debt. It will inevitably slow down our growth rate and will have disastrous outcomes for our economy.

Serious concerns relating to the appointment, formulation and composition of the Board of the Fund and the appointment of the CEO

11. The Bill invests unvetted powers to the Minister of Health

In terms of the section 12, a Board will be established to govern the Fund in accordance with the Public Finance Management Act, and such Board will be accountable to the Minister.

Currently, in terms of section 13 the Bill empowers the Minister to appoint suitable candidates to the Board after recommendations are made by an ad hoc advisory panel. However, it is proposed that due to the critical role the Board will fulfil in the overall management and functionality of the National Health Insurance Fund, greater parliamentary oversight is required.

To this effect, it may be put forward that it would be in the interest of accountability to appoint the Board in a similar fashion as the members of the SABC Board. Thus, the members of the Board should be appointed on the advice of the National Assembly, and in a manner, which would ensure transparency and openness as set out in section 13 of the Broadcasting Act 4 of 1999.

Notwithstanding the above, it may be argued that the process of appointing candidates to the Board is lacking insofar it does not compel the Minister to make an appointment from the list of recommended candidates as drawn up by the ad hoc advisory panel in terms of Section 13(3).

Section 29 determines that when the Minister is establishing a committee under this Chapter, he or she must determine by notice in the Gazette its composition, functions and working procedures, the terms, conditions, remuneration and allowances applicable to its members in consultation with the Minister of Finance and any incidental matter relating to the committee. It is objectionable that this Act provides the Minister with such carte blanche powers when it comes to the establishment of committees which are generally creatures of statute. It is recommended that the Bill specifically sets out the composition, functions and working procedures of advisory committees under this Act.

In terms of section 31(2), the Minister is compelled to clearly outline the respective roles and responsibilities of the Fund and the national and provincial Departments through legislation in order to prevent duplication of services and the wasting of resources. It may be argued that this Bill is indeed the appropriate legislation to outline these respective roles and responsibilities, as it is aimed at “creating mechanisms for the equitable, effective and efficient utilisation of the resources of the Fund”. The Bill cannot simply be mum on these respective roles and responsibilities, as it is crucial for the functioning of the Fund and setting out the relationship between the Fund and national and provincial

Departments. It is insufficient for the Department to leave matters of this nature to be legislated upon at a later stage.

Additionally, in terms of section 32(2), the Minister is empowered to introduce in Parliament proposed amendments to the National Health Act for the purpose of centralising the funding of health care services as required by this Act, which may:

a) *delegate to provinces as management agents, for the purposes of provision of health care services, and in those cases the Fund must contract with sections within the province such as provincial tertiary, regional and emergency medical services;*
b) *designate provincial tertiary and regional hospitals or groups of hospitals as autonomous legal entities accountable to the Minister through regulation; and*
c) *establish District Health Management Offices as government components to manage personal and non-personal health care services.*

The inclusion of the aforementioned section, and the sections as pointed out previously, would appear to indicate that the Department, in drafting this piece of legislation, had not undertaken a proper impact assessment insofar as the relationship with existing health legislation is concerned. The vague wording and broad powers conferred upon the Minister in terms of this section makes it clear that the Department itself has no idea how this Bill will impact on existing structures and their authorizing legislation. Furthermore, the ability to introduce legislation pertaining to health matters is already a competency of the Minister and need not be specifically legislated.

Lack of accountability

12. There are no reasonable accountability measures as the Corruption Investigating Unit is situated within the Fund which is effectively managed by the Minister

In terms of section 20(2)(e), the CEO of the Fund must establish an Investigating Unit within the office of the fund for the purposes of:

i. *investigating complaints of fraud, corruption, other criminal activity, unethical business practices and abuse relating to any matter affecting the Fund or users of the Fund; and*
ii. *liaising with the District Health Management Office concerning any matter contemplated in subparagraph (i)*

Whilst it is laudable the Bill makes provision for investigative powers in cases of corruption and maladministration within the National NHI Fund Office this does not occur, not through any independent body. With a total annual health budget of more than R220 billion and an all-encompassing Fund, it is essential that an investigative body be established that functions completely independently from the Fund, the Department, the Minister and any other related persons and entities.

13. There is no clarity on the composition of Investigating Unit

In terms of section 42(1), an affected natural or juristic person is empowered to furnish a complaint with the Fund, which the Fund must deal with in a timeous manner and in terms of the law. The Investigation Unit as established through section 20(2)(e) is compelled to launch an investigation to establish the facts of the incident reported and must make recommendations to the Chief Executive Officer as to the way in which the matter may be resolved within 30 days of receipt of the complaint in terms of section 42(2).

Currently, the Bill does not provide for the establishment, constitution and composition of the Investigation Unit. As the impartiality of this Unit is crucial to the correct functioning thereof, the Bill should in fact, in the very least, provide for the constitution and composition thereof.

14. There is no clear feedback mechanisms to complaints

Section 41(3) determines that a complainant must be informed in writing of the outcome of an investigation within a “reasonable” amount of time. It is recommended that section 41(3) be amended to provide for fixed period in which a complainant should be informed of the outcome, as delays may adversely affect complainants.

15. Insufficient process in establishment and functioning of Appeals Tribunal

Section 44(1) establishes an appeal tribunal which will consist out of five persons appointed by the Minister. The Appeal tribunal will consist out of one member appointed on account of his or her knowledge of the law, who must also be the chairperson of the Board, two members appointed on account of their medical knowledge and two members appointed on account of their financial knowledge.

In terms of section 44(2) a member of the Appeal Tribunal must serve as a member for a period of three years, which term may be renewed only once.

Section 44(3) determines that a member ceases to be a member if he or she resigns from the Appeal Tribunal; the Minister terminates his or her membership on good cause or the term for which the member was appointed has expired and has not been renewed or after a second term may not be renewed.

We would argue that Bill should make provision for further eligibility criteria and grounds for disqualification that would apply to members of the Appeal Tribunal. Additionally, the Bill should also provide for the quorum requirements insofar a decision made by the tribunal should be made by the Chairperson, and at least two other members (one skilled in the medical field, and one in the financial field) in order to ensure that its decisions are fair.

Section 45(1) provides that the Appeal tribunal will have the same powers as a High Court insofar it will be able to summon witnesses, administer an oath or affirmation, examine witnesses, and call for the discovery of documents and objects. It is recommended that the Bill specifically states that such powers should be exercised on reasonable grounds

and for the lawful purpose of exercising the functions of the Appeal Tribunal in terms of the Act.

16. Several concerns relating to eligibility of board members

With regard to the composition of the Board, section 13(5)(a)-(e) contains the eligibility criteria for members of the Board. In terms of these provisions, members must:

a) *be a fit and proper person;*
b) *have appropriate technical expertise, skills and knowledge or experience in health care service financing, health economics, public health planning, monitoring and evaluation, law, actuarial sciences, information technology and communication;*
c) *be able to perform effectively and in the interests of the general public;*
d) *not be employed by the State; and*
e) *not have any personal or professional interest in the Fund or the health sector that would interfere with the performance in good faith of his or her duties as a Board member.*

The aforementioned eligibility criteria for the appointment of Board members is also severely lacking for numerous reasons. Firstly, it may be said that it would not be suitable to merely state that a person should be a "fit and proper person" as provided for in section 13(5)(a). This is a subjective standard open to abuse and manipulation. Secondly, the Bill does not contain grounds that should automatically disqualify persons from being appointed as Board members that would, for example, include:

- Not being a citizen or a permanent resident of the Republic;
- Being declared mentally unfit or a prodigal by a court of law;
- Being convicted, after the commencement of the Act, of an offence in the Republic or elsewhere for which such person is sentenced to imprisonment without the option of a fine;
- Being convicted, before the commencement of the Act, of an offence such as theft, forgery, perjury or any other offence involving dishonesty.

Although it may be argued that these grounds would fit under the general understanding of what constitutes a "fit and proper person" for the purposes of the law, it is imperative that the Bill clearly sets out these grounds in order to prevent instances of uncertainty and unnecessary litigation.

Lastly, it should also be added that section 13(5)(e) should be broadened to include personal or professional interests in the Fund or the health sector by immediate family members which may also lead to a conflict of interests.

Section 13(7) determines that a Board member may resign by written notice to the Minister. It is suggested that such resignation also should be in accordance with recognised labour standards that would include required periods of notice.

17. The Minister can appoint his or her own representative as chairperson

In terms of section 14(1), the Minister is able to appoint a Chairperson from amongst the members of the Board. In terms of section 13(1), the Board will consist out of 11 members who are not employed by the Fund, and one member who will represent the Minister. It is put forward that section 14(1) should prevent the Minister from appointing the member of the Board who represents him or her from acting as Chairperson.

18. There's little guidance on quorums and deadlocks of the Board

Section 15(3) determines that the Board will be required to advise the Minister on any matter concerning:

a) *the management and administration of the Fund, including operational, financial and administrative policies and practices;*
b) *the development of comprehensive health care services to be funded by the Fund through the Benefits Advisory Committee;*
c) *the pricing of health care services to be purchased by the Fund through the Health Care Benefits Pricing Committee of the Board;*
d) *the improvement of efficiency and performance of the Fund in terms of strategic purchasing and provision of health care services;*
e) *terms and conditions of employment of Fund employees;*
f) *collective bargaining;*
g) *the budget of the Fund;*
h) *the implementation of this Act and other relevant legislation; and*
i) *overseeing the transition from when this legislation is enacted until the Fund is fully implemented.*

It is suggested that the Bill also specifically set out how the Board will function in terms of quorum required in order to make binding decisions, and whether the Chairperson will be the deciding vote in situations where deadlocks arise.

19. There is a lack of good and ethical governance relating to the Board and CEO

Section 16 of the Bill deals with the conduct and disclosure of interests of members of the Board. However, section 16 does not actually make provision for, or compel, members to disclose any interests that may conflict with the proper performance of his or her functions. It is submitted that this section be rectified to include such a provision.

Section 19 deals with the appointment of a Chief Executive Officer as administrative head of the Fund. It should be submitted that the eligibility criteria, or the lack thereof as pointed out above, should also extend to the appointment of the CEO.

Section 24 enables the Board to establish technical committees as may be required to achieve the purpose of the Act. It should be added that the eligibility criteria of persons to serve as members of these committees should also be strengthened.

20. Medical aids will cease to exist

It is clear from section 33 that medical aids will essentially cease to exist in their current form. The Bill states that once NHI has been "fully implemented" medical schemes may only offer complementary cover to services not reimbursable by the Fund. However, it is not clear what the NHI Bill considers to be "fully implemented". Furthermore, we believe it is possible for a private sector to co-exist next to the public sector, but with NHI the private sector will be drastically reduce, leading to job losses and poorer health outcomes.

21. The Bill discriminates against foreigners in SA

Section 4(2) determines that "asylum seekers" and illegal foreigners are only entitled to "emergency medical services" and services for notifiable conditions of public health concern. Firstly, we argue that the Bill should provide more guidance as to what constitutes an "emergency medical service" and "notifiable conditions of public health concern". Currently, the definition for "emergency medical service" is inadequate, as it does not provide for the exact meaning of "emergency".

Additionally, the Bill does not define the meaning of "notifiable conditions of public health concern". As asylum seekers and illegal foreigners are only entitled to these services in terms of the Bill, the exact scope and ambit of these services should be clearly set out.

Notwithstanding the vague nature of the health services available to asylum seekers and illegal foreigners, it should be highlighted that section 27 of the Constitution states that "everyone" has the right to access health care, and it does not expressly exclude persons on the ground of their status as asylum seekers.

We argue that the exclusion of asylum seekers from enjoying the right to universal access to quality health care services, as purported to achieve by this Act, is unconstitutional. It is trite law that the State has a constitutional obligation to protect and guarantee the constitutional rights of everyone within the borders of South Africa. The rights entrenched in the Bill of Rights are, with a few exceptions, guaranteed to citizens and non-citizens alike.

Section 4(3) determines that all children, including those of "asylum seekers" or "illegal migrants", are entitled to basic health care services as provided for in section 28(1)(c) of the Constitution. It is not clear why the Bill makes use of both the terms "illegal foreigner" and "illegal migrant" and this should be clarified.

In terms of Section 4(4), a person seeking health care services from an accredited health care service provider or health establishment must be registered as a user of the Fund and must present proof of such registration to the health care service provider or health establishment in order to secure the health care service benefits to which he or she is entitled. It is unclear how the Bill will implement or impose the condition that foreigners are required to have travel insurance in terms of section 4(5)(a) of the Bill, and this must be clarified.

22. The Bill presumes the Act will be applied retrospectively

The Act is to be implemented over two phases in terms of section 57(1)(a). According to the Bill, Phase 1 will run for a period of five years from 2017 – 2022. As 2017 has passed, it is submitted that the Bill be amended to provide that Phase 1 will run for a period of five years after the Act has been duly promulgated. In terms of the Act, Phase 2 will run for a period of four years (2022 – 2026). It is recommended that these time periods be amended in a similar fashion.

However, should this Bill already envision that Phase 1 is currently underway, questions should be posed as to the retrospective nature thereof. It is trite that legislation does not apply retrospectively, and therefore, such a provision is not permissible.

23. Implementation of NHI will likely lead to a brain-drain of critical skills in the country

The Bill states that service providers must register with the Fund in order to provide healthcare to users of the Fund. Whilst this does not compel all healthcare providers in the country to register with the Fund, it severely limits options for private practitioners. It will inevitably lead to highly skilled providers leaving the profession, a state of affairs that is not in the best interest of South Africans.

24. There are concerns about the Constitutionality of the Bill

We believe the Bill is constitutionally problematic. Proposed legislation must be based on four key principles: reasonable clarity, rational connection between purpose and proposal, an absence of retrogressive infringement of basic rights and procurement must be fair, equitable and transparent.

Throughout this submission we have argued that there are many instances in the Bill lacking clarity and that the NHI Bill will in fact not lead to universal healthcare. Furthermore, those currently covered by the private sector will undoubtedly “regress” in their healthcare coverage – essentially worsening the realisation of a basic human right.

25. Government does not have the capability to properly manage procurement processes. The failed NHI pilot projects demonstrated how poor the department was in remunerating healthcare practitioners under this system

In terms of section 10(1)(e) a key function of the Fund is to prioritise the timely reimbursement of health care services to achieve equity. As it stands, health care service providers aren’t being timeously reimbursed by. If the Fund aims to achieve such timeous reimbursement, it should set out in much more detail how it will achieve it.

Furthermore, the Genesis Report released by the Department shows that R5 billion was spent on ten pilot projects and lamented “inadequate planning, a lack of resources, inconsistent communication, a lack of coordination where necessary and insufficient mechanisms to monitor progress and thereby ensure course correction”. It is our

submission that the Department failed with the pilot projects but did not incorporate the lessons learnt into the draft legislation.

4. Conclusion

The names of the more than 87 000 South Africans are attached to this document as “addendum A”. We believe it shows the complete dissatisfaction from ordinary citizens with NHI. Government can simply not ignore these inputs. As the DA, we will continue to fight for the people of South Africa. They deserve quality healthcare, but not in the form of NHI.