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OF THE

REPUBLIC OF SOUTH AFRICA

ANNOUNCEMENTS,

TABLINGS AND

COMMITTEE REPORTS

FRIDAY, 26 MAY 2023

TABLE OF CONTENTS

ANNOUNCEMENTS

National Assembly

1. Membership of Committees..... 2

TABLINGS

National Assembly

1. Speaker..... 2

COMMITTEE REPORTS

National Assembly

1. Health 6
2. Health 9
-

ANNOUNCEMENTS

National Assembly

The Speaker

1. Membership of Committees

- (1) Ms T Mgweba has been elected Chairperson of the Portfolio Committee on Public Service and Administration, with effect from 24 May 2023.
- (2) Mr QR Dyantyi has been elected Chairperson of the Portfolio Committee on Planning, Monitoring and Evaluation, with effect from 26 May 2023.

TABLINGS

National Assembly

1. The Speaker

- (a) A petition from the residents and small business owners of Wakkerstroom in the Pixley Ka Seme Local Municipality, calling on the Assembly to investigate the condition of the roads in and around Wakkerstroom. (Mr H C C Kruger)

Referred to the **Portfolio Committee on Cooperative Governance and Traditional Affairs** for consideration and report.

- (b) Letter from the Auditor-General dated 26 May 2023, to the Speaker of the National Assembly on the publishing of the audit report of the Road Accident Fund (RAF) for the financial year ending 31 March 2022:

Dear Honourable Speaker Mapisa-Nqakula

Publishing of the audit report of the Road Accident Fund for the financial year ended 31 March 2022


1. In terms of section 21(1) of the Public Audit Act, 2004 (Act 25 of 2004) (PAA), the Auditor-General South Africa (AGSA) must submit an audit report in accordance with any legislation applicable to the auditee which is the subject of the audit.
2. The Road Accident Fund (Fund) is listed in schedule 3 of the Public Finance Management Act, 1999 (Act 1 of 1999) (PFMA) as a public entity and the AGSA must comply with the provisions of the PFMA in submitting the audit report.

3. In terms of section 55(1)(c) and (d) of the PFMA, the accounting authority for a public entity must submit, within two months after the end of the financial year, to the auditors of public entity, their financial statements for auditing and must submit within five months of the end of the financial year to the relevant treasury and executive authority responsible for the public entity, an annual report, audited financial statements and audit report.
4. The board approved the Fund's 2021-22 annual financial statements (AFS) and annual performance report (APR) and duly submitted it for auditing in line with the requirements set out in section 55(1)((c)(i) of the PFMA. I concluded the Fund's 2021-22 audit and signed the audit report on 30 September 2022. The audit opinion remained disclaimed as the Fund continued to apply IPSAS 42 to account for the provisioning for its outstanding claims liability, which was not an appropriate financial reporting framework. I submitted my report to the board under a cover letter that outlined the tabling requirements.
5. In my letter to the board, I pointed out that in terms of section 55(3) of the PFMA, the accounting authority must submit the annual report, audited financial statements and audit report to the executive authority (through the accounting officer of the department designated by the executive authority) for tabling in Parliament. Moreover, in terms of section 65(1)(a) of the PFMA, the responsible executive authority must table in the National Assembly the annual report, audited financial statements and audit report, within one month after the accounting authority for the public entity received the audit report.
6. In terms of section 21(3) of the PAA, audit reports must be tabled in the relevant legislature in accordance with any applicable legislation or otherwise within a reasonable time. If an audit report is not tabled in a legislature within one month after its first sitting after the report has been submitted by the AGSA, the AGSA must promptly publish the report.
7. In the ordinary course, an entity subject to an audit must submit its annual report to the responsible AGSA audit team for review, prior to submitting it to the executive authority for tabling. This step is critical to ensure accuracy and consistency in the message to the key users of the entity's AFS and APR. The Fund has not followed this well-known process for the submission of its 2021-22 annual report. On 28 April 2023, the Fund submitted its annual report to the audit engagement team and the responsible executive authority simultaneously.
8. Having reviewed and compared the contents of the annual report against the audit report I signed on 30 September 2022, I detected material discrepancies. These discrepancies relate to the AFS and APR included in the annual report versus my audit report, which is included in the same annual report. Upon further assessment, I noted that the discrepancies occurred because management included an unaudited version of the AFS and APR in the compilation of the 2021-22 annual report. Management has made

material adjustments to key line items in the AFS. These adjustments were not audited. The adjustments to the AFS include line items in the audited AFS relating to the following:

- a. Claims liability
 - b. Claims expenditure
 - c. Fuel levies
 - d. Irregular expenditure
 - e. Employee costs
9. We further noted that management effected adjustments to key reported indicators in the audited APR, for example:
- a. The approved Road Accident Fund business operating model
 - b. The % of all new personal claims settled within 120 days
 - c. The % of new personal claims validated and verified within 60 days
 - d. Reduced the % of 3-year-old open claims
 - e. Improved financial sustainability
10. Management did not notify the auditors of any of these adjustments.
11. I alerted management and the board of these material discrepancies. Regrettably, the board has not substituted the adjusted AFS and APR in the 2021-22 annual report with the AFS and APR that were approved by the board on 31 May 2022 and on which the audit was performed.
12. I sent a courtesy letter to the minister of transport on 15 May 2023, alerting her to these material discrepancies and the risk that these could mislead Parliament and limit its ability to exercise oversight over the Fund for the 2021-22 financial year. I also requested her intervention to ensure that the board reverts to the approved and audited AFS and APR before she tables the 2021-22 annual report in Parliament. Furthermore, I urged her to table the updated annual report by 22 May 2023, failing which I would be bound by section 21(3) of the PAA to submit the audit report for tabling in Parliament.
13. At this juncture, I do not have any legal basis for not publishing the audit report. I will therefore not exercise the discretionary power to issue a special report on the delay as provided for in section 65 (2) (b) of the PFMA.
14. As at the date of this letter, the minister of transport has not tabled the annual report, audited financial statements, audit annual performance report and audit report of the Fund as required by section 55(3) of the PFMA.
15. The AGSA hereby submits the audit report of the Fund for the year ended 31 March 2022, in line with our statutory responsibility in terms of section 21(3) of the PAA. I also attach the approved, audited version of the AFS and APR received on 31 May 2022.

Yours sincerely,



Tsakani Maluleke
Auditor-General

COMMITTEE REPORTS

National Assembly

1. Report of the Portfolio Committee on Health on the Ratification of the Treaty for the establishment of the African Medicines Agency (AMA), dated 26 May 2024

The Portfolio Committee on Health (the Committee), having considered the ratification of the treaty for the establishment of the African Medicines Agency, referred to it reports as follows:

1. The Ratification for the establishment of the African Medicines Agency Treaty was tabled in Parliament and referred to the Committee.
2. The establishment of the AMA was first discussed at the meeting of African Ministers of Health jointly convened by the African Union Commission (AUC) and the World Health Organization (WHO) in Luanda, Angola, in April 2014. The focus was to prioritise investment for regulatory capacity development and to pursue the efforts towards convergence and harmonisation of medical products regulation at the Regional Economic Communities (RECs) level.
3. The Task Team for AMA was established by the AUC to develop the modalities for the operationalisation of AMA and the development of the Treaty on AMA.
4. The African Union (AU) Assembly of Heads of State and Government adopted the Treaty in their 32nd Ordinary Session of 10-11 February 2019, in Addis Ababa, Ethiopia.
5. Rwanda was selected to host the headquarters of AMA by the Executive Council of the AU at a meeting held in Lusaka, Zambia in July 2022.
6. The main objectives of AMA are to enhance capacity of State Parties and RECs to regulate medical products in order to improve access to quality, safe and efficacious medical products in the African continent.
7. At a continental level, AMA's mission is to:

- Coordinate and strengthen ongoing initiatives to harmonise medicines regulation, promote cooperation and mutual recognition of regulatory decisions.
 - Conduct regulatory oversight of selected medical products and providing technical guidance to State Parties and RECs.
 - Pool expertise and capacities and strengthening networking for optimal use of resources.
8. In order to achieve its mandate, AMA intends to work with technical partners such as the WHO, European Medicines Agency (EMA) and the United States Food and Drug Administration (FDA) for alignment with normative standards, technical cooperation and capacity building.
9. AMA intends to develop improved access to quality-assured medical products that are expected to ensure an enhanced regulatory environment for the continent. Further, AMA plans to be more visible by facilitating the following core activities:
- Safety monitoring;
 - Market surveillance;
 - Marketing authorisation;
 - Oversight of clinical trials;
 - Coordination of quality control laboratory services; and
 - Joint assessments and Good Manufacturing Practice (GMP) Inspections.
10. The Committee received its briefing on the AMA Treaty from the Department of Health on the 17th May 2023.
11. In its presentation, the Department of Health highlighted South Africa's value proposition of the African Medicines Agency as follows:
- Globalisation means regulation is no longer solely a national responsibility;
 - Reducing the prevalence of substandard and falsified medicines and vaccines;
 - A consistent voice on regulatory issues, the pooling of expertise from across the continent;

- Regulatory harmonisation and convergence such as standards, and guidelines for quality, safety, and efficacy;
- Participation in Africa Free Trade Continental Agreement (AfCFTA) - anchored pharmaceutical initiative: localised production, pooled procurement, and harmonised regulatory and quality frameworks;
- Harmonisation is cost-effective such as speed of access to essential medicines and ensuring efficient use of resources through work-sharing; and
- Opportunity to mitigate the effects of COVID-19 pandemic by allowing the free movement of pharmaceuticals and PPE.

Votes **in favour** of the ratification of the Treaty: 7 Members (Dr KL Jacobs, Ms A Gela, Dr X Havard, Mr N Xaba, Dr J Nothnagel, Dr S Thembekwayo and Ms MD Hlengwa)

Votes **rejecting** the ratification of the Treaty: None

Abstinance: 3 Members (Ms M Clarke, Ms ERL Wilson and Mr P Van Staden)

The Committee recommends that the House, in terms of section 231(2) of the Constitution of the Republic of South Africa 1996, approves the said Treaty.

Report to be considered.

2. Report of the Portfolio Committee on Health on the National Health Insurance Bill [B11 – 2019] (National Assembly – sec 76)], dated 26 May 2023

The Portfolio Committee on Health, having considered the subject of the National Health Insurance Bill [B11 – 2019] (National Assembly – sec 76)], referred to it and classified by the Joint Tagging Mechanism as a section 76 Bill, reports the Bill with amendments [B11B– 2019].

The Committee reports as follows:

1. Context and background

The National Health Insurance (NHI) Bill [B11 – 2019] was tabled in Parliament and introduced to the Committee on the 8th August 2019.

The National Health Insurance Bill seeks to provide for the universal access to health care services in the Republic in accordance with the National Health Insurance White Paper and the Constitution of South Africa. The Bill envisages the establishment of a National Health Insurance Fund and sets out its powers, functions and governance structures. The Fund will purchase health care services for all users who are registered with the Fund. The Bill will also create mechanisms for the equitable, effective and efficient utilisation of the resources of the fund to meet the health needs of users and preclude or limit undesirable, unethical and unlawful practices in relation to the Fund. The Bill also seeks to address barriers to access.

2. Objectives of the Bill

The objects of the National Health Insurance Fund are:

- to achieve universal access to quality health care services in the Republic in accordance with section 27 of the Constitution;
- to establish a National Health Insurance Fund and to set out its powers, functions and governance structures;
- to provide a framework for the strategic purchasing of health care services by the Fund on behalf of users; to create mechanisms for the equitable, effective and efficient utilisation of the resources of the Fund to meet the health needs of the population;
- to preclude or limit undesirable, unethical and unlawful practices in relation to the Fund and its users; and to provide for matters connected herewith.

3. Parliamentary processes

The National Health Insurance Bill [B11 - 2019] was tabled in Parliament and referred to the Committee on 8th August 2019.

The Committee received its first briefing on the NHI Bill from the Department of Health on 29 August 2019.

On 4 March 2020, the Committee received a briefing from the Department of Health on the NHI pilot districts: Evaluation of Phase 1 implementation of interventions.

In facilitating effective public participation on the NHI Bill, the Committee conducted nationwide, in person public hearings in all nine provinces, from 26 October 2019 to 24 February 2020. The public hearings were attended by 11 564 members of the public and various stakeholders across 33 district municipalities. A total of 961 oral submissions were heard by the Committee during these hearings.

Additionally, the Committee conducted virtual public hearings from 18 May 2021 to 23 February 2022. The virtual public hearings afforded an opportunity to stakeholders who had expressed interest to make oral presentations of their written submissions. In total, 114 stakeholders participated in the virtual public hearings. The Committee received oral presentations from individuals and various groups such as professional associations, civil society organisations, faith-based organisations, researchers, lobby groups, academics, traditional healers, public health entities, statutory bodies, government departments, sector experts, healthcare funders, medical aid schemes, healthcare administrators, hospital groups, political organisations, labour unions and other interested stakeholders.

In addition to the provincial and virtual public hearings, the Committee received approximately 338 891 written submissions from the public. The written submissions were submitted electronically (via email) and in hard copies.

The Department of Health responded to the issues raised from the public hearings on the 29th March 2022 and 17th November 2022.

On the 18th May 2022, the Committee considered the motion of desirability on the NHI Bill. The Committee voted in favour of the motion of desirability of the NHI Bill, with seven members voting in favour of the motion and four members rejecting the motion.

The Committee proceeded to the formal stage of the Bill, that is, the clause by clause deliberations on the NHI Bill, from 01 June 2022 to 16 November 2022.

On the 22nd November 2022, the Committee considered its matrix on the consolidated public submissions from all stakeholders, recommendations and proposed amendments, to which the Department responded to on 30th November 2022.

On the 15th March 2023, the Committee received legal advice from the Parliamentary Legal Advisor and the State Law Advisors on issues raised during public hearings and the Committee's deliberations on the clauses of the Bill.

3.1. Legal opinion from the Parliamentary Legal Advisor and State Law Advisors

The Parliamentary Legal Advisor's input on the NHI Bill. On the Competition Act, the Committee was informed about the provisions of the Competition Act and that the Act seeks to prevent and prosecute anti-competitive behaviour and allows the Competition Commission to investigate such behaviour at the pain of a possible fine. The Parliamentary Legal Advisor indicated that the wording of clause 3(5) is broad in that it excludes all transactions concluded in terms of the NHI Bill from the application of the Competition Act. She further noted that this exclusion will apply not only to the NHI Fund but also to all parties who contract with the NHI Fund, including service providers and suppliers and this may create an opportunity of anti-competitive behaviour. Further, the exclusion will not be in keeping with the Constitution to ensure fair, equitable, transparent, competitive and cost effective procurement. It was indicated that the proposal to limit exclusion in clause 3(5) to only the NHI Fund was agreed to.

On Access to Health Care, the Committee was informed about the provisions of the Constitution with regard to access to health care. It was noted that in terms of the NHI Bill, asylum seekers are entitled to emergency medical services and services for notifiable conditions of public health concern. Refugees are entitled to the same health care services as South African citizens. In terms of the Bill, asylum seekers will no longer enjoy access to primary health care services, reproductive health care and antiretroviral therapy and that those who do not have financial means will have no alternative manner to access health care services.

The Parliamentary Legal Advisor also indicated that the NHI Bill does not set out a process to register other vulnerable groups who may be unable to register as NHI users and these include aged persons and mentally challenged adults. It was recommended that the Committee should consider making provision for the registration of other vulnerable groups.

The State Law Advisors noted the main purpose of the NHI Bill. It was highlighted that the quality of health care services will be achieved by ensuring the sustainability of funding for health care services within the Republic and providing for equity and efficiency in funding by the pooling of funds and strategic purchasing of health care services, medicines, health goods and health related products from accredited and contracted health care service providers. Reference was made to the instructive in analysis relating to policy decisions, the Constitutional Court in *Minister of Health and Others v Treatment Action Campaign and Others (No 2)*.

The State Law Advisor indicated that in the context of concurrent national and provincial legislative competence, the drafters of the Constitution contemplated a situation where there could be a conflict between the national and provincial legislation regarding a matter listed in Schedule 4 to the Constitution provides for a mechanism to resolve any conflict between national and provincial legislation. The State Law Advisors said they hold a view that the Bill falls within the ambit of health services which is a functional area listed in Part A of Schedule 4 since it deals with the types and manner of services by medical practitioners, generally that may be accessed and supplied.

3.2. Deliberations on the Legal Advisors' input

On the 22nd March 2023, the Committee conducted a meeting to deliberate on the Parliamentary Legal opinion and the State Law Advisors Opinion. The opposition parties (DA, FF-Plus and EFF) requested that the meeting be postponed as they needed to consult about the two legal opinions. The Committee did not agree to their request and they walk out of the meeting.

The following members walked out of the meeting: Ms M Clarke; Ms ERL Wilson; Dr S Thembekwayo; Ms N Chirwa and Mr P Van Staden

Members of the ANC continued and deliberated on the two legal opinions received.

On the 29th March 2023, the Committee conducted a meeting to further discuss the final amendments on the Bill. It was agreed in that meeting that opposition parties will be granted a week's extension to consult on the legal opinions.

On the 10th May 2023 the Freedom Front Plus presented its legal opinion on the NHI Bill as follows:

Summary of the Freedom Front Plus (FF-Plus) Legal Opinion

1. Introduction

- 1.1 The Freedom Front Plus obtained a legal opinion from Steyn du Toit Attorneys, on the National Health Insurance Bill [B11 - 2019] (hereinafter the "Bill") which has been submitted to this Committee Chairperson for consideration by the State Law Advisors and the Chief Legal Advisor of Parliament.
- 1.2 The mandate to the firm was to advise whether the Bill would pass constitutional muster, taking into consideration the relevant constitutional rights, obligations, the limitation and application thereof, the principles of law applicable, and overall, whether the Bill is consistent with the Constitution of the Republic of South Africa, 108 of 1996 (hereinafter the

“Constitution”) and properly drafted in the form and style which confirms to legislative practice.

2. Background

- 2.1 The PCH received two legal opinions on the Bill from respectively, the Chief Legal Advisor of the Parliament of the Republic of South Africa, and the office of the Chief State Law Advisor on 15 March 2023. Since these opinions were seemingly contradictory, with specific reference on the question of the constitutionality of the Bill, members of the PCH from opposition parties (myself being from the Freedom Front Plus) requested an opportunity to obtain their own legal opinions, which was granted.
- 2.2 The Chairperson of the PCH afforded members a final opportunity to 5 April 2023 to obtain their own legal opinions.

3. Does the Bill pass Constitutional muster?

3.1 Purpose of the Bill

- 3.1.1 The main purpose of the Bill is to establish and maintain a National Health Insurance Fund (hereinafter the “NHI Fund”) in the Republic of South Africa through mandatory prepayment that aims to achieve sustainable and affordable universal access to quality health care services.
- 3.1.2 The Bill sets out a range of health policy interventions, including the establishment of the National Health Insurance Fund (hereinafter “NHI Fund”) to progress the achievement of universal health coverage (hereinafter “UHC”).
- 3.1.3 The Bill proposes an overhaul of the health care system in South Africa, introducing a range of structures for both governance of the NHI Fund, and the purchasing of health care services.
- 3.1.4 The concept of universal healthcare or universal health coverage is of course praiseworthy, on the understanding that it will grant access to healthcare services by all who require access.
- 3.1.5 The opinion refers to some authority and sources, which I will not reference time and again in this presentation, as it is properly cited in the opinion and I am only afforded some 5 – 7 minutes to present the opinion.

3.2 Section 27: Access to Health Care

- 3.2.1 The provision of health care is a constitutional right as contained in Section 27(1) of the Constitution:¹
- 3.2.2 What Section 27(1) provides for, is the right to have access to, *inter alia*, health care services. Section 27(2) in essence determines that it is the duty of the State to take reasonable legislative and other measures, **within its available resources**, to achieve the **progressive realisation** of access to health care services. In practice, the services to be accessed are limited by the practicalities in providing such access in respect of available health care resources and the cost of such services. The Bill similarly refers to the same goals and similar wording in the preamble.
- 3.2.3 Section 27 of the Constitution imposes a 'positive' obligation on the state to realise the right of access to healthcare within the state's available resources and a 'negative' obligation not to take steps that are retrogressive. In considering the aforesaid, if there is a high risk of the Bill not achieving its objectives, the state could fail in its positive obligation, and if the Bill results in reduced access to healthcare services, the state would also fail in its negative obligation.²
- 3.2.4 The matter of *Soobramoney v Minister of Health (KwaZulu-Natal)*³ is a matter, which was decided in the Constitutional Court and gives a practical illustration of the application of Section 27(2) of the Constitution.
- 3.2.5 In *Ex Parte Chairperson of the Constitutional Assembly: in re Certification of the Constitution of the Republic of South Africa 1996*⁴ the Constitutional Court made the point that socio-economic rights could at the least be negatively protected. Negative protection is the form of judicial protection conventionally given to civil and political rights. This means that there is a negative obligation not to interfere with someone who is enforcing or exercising a constitutional right. This means that a court can prevent the state from acting in ways that infringe the socio-economic rights directly. The right to health care, should therefore not be subjected to deliberately retrogressive measures that is denying individuals their existing access to, for instance, health care. A law leading to a decline rather than progressive improvement in conditions, could be a violation of this negative aspect of the socio-economic right and could be declared invalid for this reason. The positive obligations imposed by socio-economic rights are subject to progressive realisation, the right of "access".

¹ 108 of 1996, as amended

²Solanki G, Wild S, Cornell J, Brijlal V. *Thematic analysis of the challenges and options for the Portfolio Committee on Health in reviewing the National Health Insurance Bill* SAMJ: South African Medical Journal vol 112 n.7 Pretoria Jul 2022. <http://dx.doi.org/10.7196/SAMJ.2022.v112i7.16644> (accessed 4 April 2023).

³*Soobramoney v Minister of Health (KwaZulu-Natal)* 1998 (1) SA 765 (CC).

⁴*Ex Parte Chairperson of the Constitutional Assembly : in re certification of the Constitution of the Republic of South Africa 1996 (first certification judgment)* 1996 (4) SA 744 (CC) pp 77 – 78

- 3.2.6 Turning to the requirement of progressive realisation, the Constitutional Court in the *Soobramoney* decision held the following:

“What is apparent from these provisions is that the obligations imposed on the State by ss 26 and 27 in regard to access to housing, health care, food, water and social security are dependent upon the resources available for such purposes, and the corresponding rights themselves are limited by reasons of lack of resources. Given this lack of resources and significant demand on them that have already been referred to, an unqualified obligation to meet these needs would not presently be capable of being fulfilled. This is the context within which s 27(3) must be construed.”⁵

- 3.2.7 This suggests that the positive dimension of the socio-economic right is realised or fulfilled through the state progressively or over a period of time. The burden is on the state to show that it is making progress towards the full realisation of the rights.⁶

- 3.2.8 The socio-economic rights are further limited by the qualification that they are only available to the extent that the state resources permit. In the absence of available state resources, the failure of the state to address socio-economic rights is therefore not a violation of the right.⁷

- 3.2.9 The content of the Thematic Report on Public Submissions confirmed that both National Treasury as well as the Davis Tax Committee has expressed its reservations in regard to available funding for the NHI fund.

- 3.2.10. If the National Health Insurance Fund has been fully implemented, medical aid schemes may only offer complimentary cover to services not reimbursable by the NHI Fund. This in return means that more than 9 million people who are now carried by private medical aid insurances, will then become the burden of the State. There is therefore an argument that the intended legislation will increase the burden on the State instead of strengthening the capacity of the State, even if one assumes that the contributions which would have been paid over to medical aid schemes, is now contributed to the NHI Fund in the form of imposed tax. It is therefore argued that the possibility exists that, instead of improving the right of access to efficient health care services, the existing right to access to health care which members of private medical aids currently hold and pay for, may be diminished by the very Bill which aims to achieve the realisation of this right.

- 3.2.11 It is submitted that some of the provisions contained in the Bill will have the further likely effect of preventing access to health care services, especially

⁵Soobramoney v Minister of Health (KwaZulu-Natal) (1) SA 765 (CC) – par. 11.

⁶I Currey & J de Waal *The Bill of Rights Handbook* (6th Ed) p580.

⁷ See I Currey & J de Waal *The Bill of Rights Handbook* (6th Ed) p581.

if a person who is eligible to receive health care services have not registered with the NHI Fund.

3.2.12 The prescribed referral pathways are in conflict with the Patients' Rights Charter,⁸ which makes provision for the right of patients to choose their own healthcare provider or health facility.⁹ "Referral pathway rules would prevent people from continuing a relationship with their doctor of choice,¹⁰ and were 'prejudicial to pregnant women who prefer to engage their regular gynaecologist or obstetrician'.¹¹ The proposed referral pathways place continuity, quality and efficiency of care at risk, especially for patients with complex conditions or longstanding chronic conditions. There would be unnecessary waiting periods, and 'access delayed may be access denied'.¹²

3.2.13 The prescribed referral network could limit access to care. There is a lack of clear guidelines for referral of persons with disabilities and their families from rural areas to a designated state hospital, and no recognition of their need for transport and accommodation. This could limit coverage and/or increase costs for users who had to travel to other facilities because their nearest facility was not accredited.¹³

⁸National Department of Health, South Africa. The Patients' Rights Charter. <https://www.idealhealthfacility.org.za/App/Document/Download/150> (accessed 4 April 2023).

⁹Genetic Alliance presentation to Portfolio Committee on Health. National Health Insurance (NHI) Bill, public hearings day 25. 8 February 2022. <https://pmg.org.za/committee-meeting/34280/> (accessed 4 April 2023). Solanki G, Wild S, Cornell J. Brijlal V. *Thematic analysis of the challenges and options for the Portfolio Committee on Health in reviewing the National Health Insurance Bill* SAMJ: South African Medical Journal vol 112 n.7 Pretoria Jul 2022. <http://dx.doi.org/10.7196/SAMJ.2022.v112i7.16644> (accessed 4 April 2023).

¹⁰ Professional Provident Society presentation to Portfolio Committee on Health. National Health Insurance (NHI) Bill, public hearings day 25. 8 February 2022. <https://pmg.org.za/committee-meeting/34280/> (accessed 4 April 2023). Solanki G, Wild S, Cornell J. Brijlal V. *Thematic analysis of the challenges and options for the Portfolio Committee on Health in reviewing the National Health Insurance Bill* SAMJ: South African Medical Journal vol 112 n.7 Pretoria Jul 2022. <http://dx.doi.org/10.7196/SAMJ.2022.v112i7.16644> (accessed 4 April 2023).

¹¹Commission for Gender Equality presentation to Portfolio Committee on Health. National Health Insurance (NHI) Bill, public hearings day 24. 28 January 2022. <https://pmg.org.za/committee-meeting/34148/> (accessed 4 April 2023). Solanki G, Wild S, Cornell J. Brijlal V. *Thematic analysis of the challenges and options for the Portfolio Committee on Health in reviewing the National Health Insurance Bill* SAMJ: South African Medical Journal vol 112 n.7 Pretoria Jul 2022. <http://dx.doi.org/10.7196/SAMJ.2022.v112i7.16644> (accessed 4 April 2023).

¹²Solanki G, Wild S, Cornell J. Brijlal V. *Thematic analysis of the challenges and options for the Portfolio Committee on Health in reviewing the National Health Insurance Bill* SAMJ: South African Medical Journal vol 112 n.7 Pretoria Jul 2022. <http://dx.doi.org/10.7196/SAMJ.2022.v112i7.16644> (accessed 4 April 2023).

¹³Solanki G, Wild S, Cornell J. Brijlal V. *Thematic analysis of the challenges and options for the Portfolio Committee on Health in reviewing the National Health Insurance Bill* SAMJ: South African Medical Journal vol 112 n.7 Pretoria Jul 2022. <http://dx.doi.org/10.7196/SAMJ.2022.v112i7.16644> (accessed 4 April 2023).

- 3.2.14 The draft Bill does not clarify what specific health care services are to be provided. The Bill defines “health care service” as: *“health care services, including reproductive health care and emergency medical treatment, contemplated in Section 27 of the Constitution”*. This definition does not advance the interaction between access and what is to be accessed. Whilst clause 2 of the Bill proposes a mandatory pre-payment system to achieve *“sustainable and affordable universal access to quality health care services”*, the services remain oblique and unclear.
- 3.2.15 Given the high risk of the Bill not achieving its objectives, the State could fail in its positive obligation, and if the Bill results in reduced access to healthcare services, the state would also fail in its negative obligation, which will in turn give rise to a constitutional challenge.
- 3.2.16 Another way in which the Bill would not pass Constitutional muster, is in its treatment of the rights of asylum seekers and migrants.
- 3.2.17 Section 27(3) of the Constitution provides that: “no one may be refused emergency medical treatment”. The State’s duty under Section 27(3) is *“not to refuse ambulance or other emergency services which are available”* and *“not to turn a person away from hospital which is able to provide the necessary treatment”*. This available and able qualification makes it clear that Section 27(3) does not create a positive constitutional obligation on the State to ensure that emergency medical facilities are made available so that no one in an emergency situation can be turned away. Section 27 allows for everyone to have the right to access to healthcare. Section 27(3) is therefore a right not to be arbitrarily excluded from that which already exists.¹⁴
- 3.2.18 In terms of the Bill, an asylum seeker will no longer enjoy access to primary health care services should the Bill therefore pass and limits the rights of asylum seekers to access to health care. This will have the effect that the State will be impairing existing rights. It will also have the effect of violating the non-refoulment principle if asylum seekers are forced to leave because of failure to access healthcare.¹⁵
- 3.2.19 The same argument is applicable to children. Section 4(3) of the Bill provides that:

¹⁴ Currey & J de Waal *The Bill of Rights Handbook* (6th Ed) p593

¹⁵ Solanki G, Wild S, Cornell J, Brijlal V. *Thematic analysis of the challenges and options for the Portfolio Committee on Health in reviewing the National Health Insurance Bill* SAMJ: South African Medical Journal vol 112 n.7 Pretoria Jul 2022. <http://dx.doi.org/10.7196/SAMJ.2022.v112i7.16644> (accessed 4 April 2023).

“All children, including children of asylum seekers or illegal migrants, are entitled to basic health care services as provided for in Section 28(1)(c) of the Constitution.”

- 3.2.40 Since the Bill does not define the term “health care services”, it runs the risk of constitutional challenge in the event that children will not be receiving the same level of health care services as currently provided to them in terms of the National Health Act.

3.3. Section 22: Right to Freedom of Trade, Occupation and Profession

- 3.3.1 Clause 2 of Chapter 1 of the National Health Insurance Bill provides that the National Health Insurance Fund will serve as the single purchaser and single payer of health care services.

- 3.3.2 This provision may possibly infringe on Section 22 of the Constitution, in that the National Health Insurance Fund may very well monopolize the health care insurance industry.

- 3.3.3 Another noteworthy departure of the Bill, is found in Clause 3(5) , which provides that:

“The Competition Act 1998 (Act No. 89 of 1998) (“the Competition Act”), is not applicable to any transactions concluded in terms of this Act.”

- 3.3.4 The aim of the Competition Act is to prevent and prosecute anti-competitive behaviour and allows the Competition Commission to investigate such behaviour at the risk of a possible fine.

- 3.3.5 The wording of the Act may have the end result and opportunity for anti-competitive behaviour.

- 3.3.6 Section 217(1) of the Constitution provides that when the procurement for goods and services are undertaken by an organ of state or any other institution identified in National legislation, it must be done in accordance with a system which is fair, equitable, transparent, **competitive** and cost effective. It is therefore submitted that the exclusion will therefore constitute a possible contravention of Section 217 of the Constitution.

4. Governance and Accountability

- 4.1 It is submitted that it is not correct that the NHI Fund be authorized to investigate complaints against itself.

- 4.2 Clause 13 makes provision for the Minister to appoint the Board of the Fund, as well as the Chairperson of the Fund. In terms of clause 13(3), an *ad hoc* advisory panel appointed by the Minister must conduct public interviews of

shortlisted candidates and forward their recommendations to the Minister for approval. There is no provision for the criteria which the Minister will have to apply to appoint the *ad hoc* advisory panel.

- 4.3 Section 2 and Section 44(4) of the Constitution state that, in exercising its legislative authority, Parliament must act in accordance with, and within the limits of, the Constitution and the supremacy of the Constitution requires that the obligations imposed by it must be fulfilled.
- 4.4 The beneficiary's peculiarly vulnerable to or at the mercy of the fiduciary holding the discretion of all power.
- 4.5 It is submitted that these clauses fall short from a governance perspective.

5. Infringement of Provincial Responsibility

- 5.1 The Bill does not allow for provinces to purchase health care services. It significantly reduces the powers and responsibilities of provinces as set out in the Constitution, the National Health Act and the PFMA¹⁶. A single purchaser/payer provision of the Bill infringes on the constitutionally mandated responsibility of provinces to ensure the progressive realisation of the rights of access to health care services, as set out in Chapter 4 of the Constitution.¹⁷
- 5.2 Section 44(1)(a)(ii) and Section 104(1)(b)(i) of the Constitution vests concurrent legislative authority in Parliament and Provincial Legislatures over the area of health services.
- 5.3 Since the Bill seeks to change some of the functions conferred on Provinces in terms of the National Health Act, by removing certain functions currently performed by the Provincial Department of Health, this will have the effect of removing the authority of Provinces and may be unconstitutional.

6. Medical Schemes

- 6.1 The Bill is silent on details on how medical scheme will operate once the Bill is enacted. It is furthermore not clear how current medical schemes will access health care services during the phased implementation of the Bill.

¹⁶South Africa. Public Finance Management Act No 1 of 1999. <http://www.treasury.gov.za/legislation/PFMA/actpdf> (accessed 4 April 2023).

¹⁷Solanki G, Wild S, Cornell J, Brijlal V. *Thematic analysis of the challenges and options for the Portfolio Committee on Health in reviewing the National Health Insurance Bill* SAMJ: South African Medical Journal vol 112 n.7 Pretoria Jul 2022. <http://dx.doi.org/10.7196/SAMJ.2022.v112i7.16644> (accessed 4 April 2023).

- 6.2 The consequences of curtailing and limiting the service offering by medical schemes has the potential to undermine the stability of the existing medical schemes market.
- 6.3 Although the Bill may not be compelling a person to become a user of the National Health Insurance Scheme, by making payment of contributions to the fund mandatory, it endeavours to entice the population to join the fund in order to gain access to needed health care services that will not be available from alternative sources such as medical schemes.
- 6.4 Limiting people from purchasing medical scheme coverage they seek may seriously curtail the health care they expect and demand. It poses the risk of eroding sentiment and of denuding the country of critically needed skills. Ultimately, by preventing those who can afford it, from using their medical scheme cover and forcing them into the NHI system, this approach may have the effect of increasing the burden on the NHI and will drain the very resources that must be used for people in most need.
- 6.5 Because the Bill is silent on the role of medical schemes and how it will access health care services during the implementation of the Bill, this creates legal uncertainty.

7. Problematic Provisions of the Bill

- 7.1 The language of the Bill, as it currently stands, creates legal uncertainty, contrary to the principle of the rule of law, which is a founding value of the Constitution, to be found in Section 1 of the Constitution.
- 7.2 The rule of law requires that laws must be clear and accessible. A law that does not indicate with reasonable certainty to those who are bound by it, what is required of them, so that they may regulate their conduct accordingly, is vague and accordingly unconstitutional and invalid.¹⁸ See *Affordable Medicines Trust v Minister of Health* 2006 (3) SA 247 (CC) [108]; *Minister of Health v New Clicks South Africa (Pty) Ltd* 2006 (2) SA 311 CC [246].

8. Public Participation

- 8.1 Sections 59 and 72 of the Constitution compel Parliament to facilitate public involvement in its legislative and other processes. Our courts have rejected the argument that the public need not participate in the legislative process as its elected representatives are speaking on the public's behalf.¹⁹

¹⁸ Currey & J de Waal *The Bill of Rights Handbook* (6th Ed), p14

¹⁹ *Land Access Movement of South Africa and Others v Chairperson of the National Council of Provinces and Others* (CCT40/15) [2016] ZACC 22; 2016 (5) SA 635 (CC); 2016 (10) BCLR 1277 (CC) (28 July 2016) at par 57.

- 8.2 It is therefore recommended that the PCH should, in the Thematic Report, report on the exact numbers for and against the proposed NHI Bill and, if necessary, have the necessary supporting documentation available for scrutiny by all members of the committee.

9. Conclusion

- 9.1 For the reasons, as set out above, it is recommended, from the point of proper compliance with the concept of public participation, that the Thematic Report indicates the exact number of comments for and against the proposed NHI Bill.
- 9.2 It is the opinion of the firm that the Bill, as it stands and without addressing some of the pertinent constitutional issues and concerns raised with reference to the achievement of the progressive realisation of the right to access to health care services, as provided for in section 27 of the Constitution, the perceived limitation of existing rights of private medical aid members, foreigners and children, will not pass constitutional muster and may in fact have the opposite effect than initially intended, in that it may frustrate, impede on and limit existing access to health care of many citizens, children and foreigners.
- 9.3 It is submitted that if current medical scheme users suffer a reduction in access to health care as the result of the full implementation of the NHI, this will give rise to a constitutional challenge based on a violation of Section 27(1) - (2) of the Constitution.
- 9.4 As demonstrated in the matter of *Grootboom*²⁰, legislative measures by themselves are not likely or sufficient to constitute constitutional compliance. The state is obliged to achieve the intended result, as set out in the Bill, in compliance with the Constitution and legislative measures will enviably have to be supported by appropriate, well directed policies and programmes, implemented by the executive, which must be reasonable both in their conception and implementation. Without funding, the legislative measures, as envisaged by the Bill, as well as any well directed policies and programmes, will not constitute constitutional compliance with section 27 and may in fact achieve the opposite by negatively impacting on existing rights. Instead of implementing the Bill, the focus should be on strengthening existing capacity in the public health system, by progressively achieving access to health care services in terms of existing means.
- 9.5 There are serious and legitimate concerns, raised from various participants on the issue of governance as well the proposed structure intending to deal with the NHI Fund. These issues need to be addressed.

²⁰ *Government of Republic of South Africa v Grootboom* 2001 (1) SA 46 (CC).

- 9.6 Very real concerns arise from the current formulation of various clauses of the Bill, and therefore non-compliance with the principle of the rule of law. The rule of law requires that laws must be clear and accessible. The Bill does not indicate with reasonable certainty to those who will be bound by it, what is required of them, so that they may regulate their conduct accordingly. Because the Bill is vague, it will accordingly run the risk of being found unconstitutional and invalid.
- 9.7 As stated before and given the high risk of the Bill not achieving its objectives, the State could fail in its positive obligation, and if the Bill results in reduced access to healthcare services, the state would also fail in its negative obligation, which will in turn give rise to a constitutional challenge.
- 9.8 The Bill also faces severe constitutional challenges from the point of view of the infringement of constitutional rights of access to health care, as, it currently undermines and negates the role of provinces and medical schemes to a great extent.
- 9.9 It is the opinion of the firm that Parliament, in passing the proposed Bill, would risk a constitutional challenge by interested and affected parties.

3.3. Consideration and adoption of the A-list and B-Bill

On the 12th May 2023, the Committee considered and adopted the A-List of the NHI Bill. Members of the ANC (Dr KL Jacobs, Ms A Gela, Dr X Havard, Mr N Xaba, Mr M Dlamini and Dr J Nothnagel) and IFP (Ms MD Hlengwa) supported the A-list. Opposition parties, the DA (Ms M Clarke and Ms ERL Wilson) EFF (Dr S Thembekwayo) FF Plus (Mr Van Staden) rejected the A-List.

On the 24th May 2023, the Committee considered and adopted the A-List and the B-Bill. Members of the African National Congress (Dr KL Jacobs, Ms A Gela, Dr X Havard, Mr NV Xaba, Mr M Dlamini and Dr J Nothnagel) voted in support of the A-List and the B-Bill. Members of the Democratic Alliance (Ms M Clarke and Ms ERL Wilson), Economic Freedom Fighters (Ms N Chirwa) and Freedom Front Plus (Mr P Van Staden) rejected the A-List and the B-Bill.

The amendments agreed to by the Committee are as follows:

CLAUSE 1

1. On page 5, after line 26, to insert the following definition:
 “ **‘basic health care services’** means services provided by health care service providers which are essential for maintaining good health and preventing serious health problems including preventative services, primary

- health care, emergency medical services, diagnostic services, treatment services and rehabilitation services;”.
2. On page 6, in line 2, to omit “pre-hospital”.
 3. On page 6, after line 23, to insert the following definition:
 “ ‘**health product**’ means a product regulated in terms of the Medicines and Related Substances Act, 1965 (Act No. 101 of 1965), the Hazardous Substances Act, 1973 (Act No. 15 of 1973), the Foodstuffs, Cosmetics and Disinfectants Act, 1972 (Act No. 54 of 1972), or any other product regulated by a law governing its quality, efficacy or performance and used in the provision of health care services;”.
 4. On page 7, after line 26, to insert the following definition:
 “ ‘**supplier**’ means a natural or juristic person in the public or private sector providing goods and services other than personal health care services;”.
 5. On page 7, in line 28, after “Minister” to insert “and directive issued by the Fund”.

CLAUSE 3

1. On page 8, from line 1, to omit subsection (5) and to substitute the following subsection:
 “(5) The Fund is exempt from the Competition Act, 1998 (Act No. 89 of 1998), to enable it to fulfil its mandate as a single purchaser and single payer as contemplated in section 2.”.

CLAUSE 4

1. On page 8, in line 19, to omit “migrants” and to substitute “foreigners”.
2. On page 8, in line 23, to omit “such registration” and to insert “identity”.

CLAUSE 5

1. On page 8, in line 55, to omit “foreign nationals” and to substitute “foreigners”.
2. On page 9, in line 1, to omit “Unaccredited” and to substitute “Accredited”.
3. On page 9, in line 4, to omit “user” and to substitute “person”.
4. On page 9, in line 5, after “must” to insert “be registered as a user and”.
5. On page 9, in line 6, to omit “registration” and to substitute “identity”.

CLAUSE 6

1. On page 9, from line 10, to omit “, within the State’s available and appropriated resources”.
2. On page 9, in line 13, after “care” to insert “service”.
3. On page 9, in line 14, to omit “registration” and to substitute “identity”.
4. On page 9, in line 49, to omit “any other private health insurance scheme” and to substitute “private insurance covering an international traveller with a short-term, work or student visa”.

CLAUSE 7

1. On page 10, from line 24, to omit subparagraph (i) and to substitute the following subparagraphs:
 - “(i) the Minister must request the Minister of Public Service and Administration to consider and assist in the establishment of central hospitals as national government components in accordance with section 7(5) of the Public Service Act, 1994 (Proclamation No. 103 of 1994);
 - (ii) where central hospitals are not established as national government components, the Minister must establish or designate central hospitals as organs of state in an appropriate form;”.

CLAUSE 8

1. On page 11, from line 1, to omit subsection (2) and to substitute the following subsection:

“(2) A person or user, as the case may be, must pay for health care services rendered directly or through a voluntary medical insurance scheme registered under the Medical Schemes Act or through a private insurance covering an international traveller with a short-term, work or student visa or out of pocket payment, if that person or user—

 - (a) is not entitled to health care services purchased by the Fund in terms of this Act;
 - (b) seeks services that are not deemed medically necessary by the Benefits Advisory Committee;
 - (c) seeks services that are not covered by the Fund as prescribed;
 - or
 - (d) seeks services that are not included in the comprehensive health care services as advised by the Benefits Advisory Committee.”.

CLAUSE 11

1. On page 12, in line 16, to omit “outlined” and to substitute “contemplated”.
2. On page 12, from line 43, to omit subparagraph (iv) and to substitute the following subparagraph:

“(iv) receiving and collating all required data from health care service providers, health establishments and suppliers for the efficient running of the Fund;”.

CLAUSE 13

1. On page 13, from line 25, to omit subsection (1) and to substitute the following subsection:

“(1) The Board consists of not more than 11 persons—

- (a) who broadly reflect the diversity of the Republic including in respect of age, race, gender and disability; and
 - (b) who are appointed by the Minister, one of whom represents the Minister on the Board.”
- 2. On page 13, in line 32, after “approval” to insert “by Cabinet”.
- 3. On page 13, from line 56, to omit subsection (9) and to substitute the following subsections:
 - “(9) The Minister may dissolve the Board only after an inquiry is conducted into the Board and Cabinet approves the dissolution.
 - (10) When the Board is dissolved, the Minister—
 - (a) must appoint an interim Board to carry out the functions of the Board for a period not exceeding three months, subject to any conditions he or she may require; and
 - (b) must, as soon as practicable but not later than three months from the day the Board is dissolved, appoint a Board in the manner contemplated in this section.
 - (11) When a vacancy occurs at any time before the expiry of the term of office of a member of the Board, the Minister—
 - (a) must appoint any other person to carry out the functions of a Board member for a period not exceeding three months, subject to any conditions that the Minister may require; and
 - (b) must, as soon as practicable but not later than three months from the day the vacancy occurs, appoint a member of the Board in the manner contemplated in this section.”.

CLAUSE 14

- 1. On page 14, in line 10, after “must” to insert “, after consultation with Cabinet,”.

CLAUSE 15

- 1. On page 14, from line 25, to omit paragraph (a) and to substitute the following paragraph:
 - “(a) the financial and administrative policies of the Fund;”.
- 2. On page 14, after line 50, to insert the following subsection:
 - “(5) The Board and Chief Executive Officer must meet with the Minister and the Director-General of the Department at least twice a year in order to exchange information necessary for the Board to carry out its responsibilities.”.

CLAUSE 16

- 1. On page 15, in line 6, after “direct”, to insert “or indirect”.

CLAUSE 17

1. Clause rejected.

NEW CLAUSE

1. That the following be a new clause to follow after clause 16:

“Quorum, decisions and procedures

17. (1) A majority of all the members of the Board constitutes a quorum for a meeting of the Board.

(2) Any matter before the Board is decided by the votes of the majority of the members present at the meeting: Provided that—

(a) the members present constitute a quorum for a meeting of the Board; and

(b) the member presiding at the meeting must exercise a casting vote in addition to that member’s vote as a member, if there is an equality of votes.

(3) The Board must determine its own procedures in consultation with the Minister.”.

CLAUSE 19

1. On page 15, in line 22, to omit “recommendations” and to insert ‘recommendation’.
2. On page 15, in line 23, after “of” to insert “approval by Cabinet of the”.
3. On page 15, in line 32, after “Officer” to insert “, after a fair hearing,”.

CLAUSE 20

1. On page 15, in line 45, after “direction” to insert “and advice”.
2. On page 15, after line 48, to insert the following paragraphs:
“(c) terms and conditions of employment of the staff of the Fund;
(d) collective bargaining relating to the staff of the Fund;”.
3. On page 15, in line 52, to omit “an Investigating Unit” and to substitute “a Risk Management and Fraud Prevention Investigation unit”.
4. On page 16, in line 13, before “Procurement” to insert “Health Products”.
5. On page 16, in line 15, after “Risk” to insert “Management”.

CLAUSE 21

1. On page 16, in line 38, to omit "Minister".
2. On page 16, in line 40, to omit "of the Fund" and to substitute "and the Board".
3. On page 16, in line 40, to omit "Minister, ".
4. On page 16, in line 41, to omit "Health" and to substitute "the Department".

CLAUSE 23

1. On page 17, after line 4, to insert the following subsection:
 "(5) A member of a committee contemplated in subsection (1) must—
 (a) act in a way that is impartial and without fear, favour or prejudice;
 (b) not expose himself or herself to any situation in which the risk of a conflict between his or her official responsibilities and private interests may arise; or
 (c) not use his or her position or any information entrusted to him or her for self-enrichment or to improperly benefit any other person."

CLAUSE 24

1. On page 17, after line 21, to insert the following subsection:
 "(5) A member of a committee contemplated in subsection (1) must—
 (a) act in a way that is impartial and without fear, favour or prejudice;
 (b) not expose himself or herself to any situation in which the risk of a conflict between his or her official responsibilities and private interests may arise; or
 (c) not use his or her position or any information entrusted to him or her for self-enrichment or to improperly benefit any other person."

CLAUSE 25

1. On page 17, from line 35, to omit "when he or she is no longer a member of the institution that nominated him or her or".

CLAUSE 28

1. Clause rejected.

NEW CLAUSE

1. That the following be a new clause to follow after clause 27:

“Conduct and disclosure of interest

28. (1) A person appointed as a member of a committee contemplated in this Chapter must—

- (a) be a fit and proper person;
- (b) have appropriate expertise and experience; and
- (c) have the ability to perform effectively as a member of that committee.

(2) A member contemplated in subsection (1) must—

- (a) act in a way that is impartial and without fear, favour or prejudice;
- (b) not expose himself or herself to any situation in which the risk of a conflict between his or her official responsibilities and private interests may arise; or

- (c) not use his or her position or any information entrusted to him or her for self-enrichment or to improperly benefit any other person.

1. A member contemplated in subsection (1) who has a personal or financial interest in any matter in which such committee gives advice, must disclose that interest when that matter is discussed and be recused from the discussion.”.

CLAUSE 35

2. On page 19, in line 52, to omit “transfer funds” and to substitute “reimburse payment”.
3. On page 19, from line 55, to omit “transferred to Contracting Units for Primary Health Care” and to substitute “reimbursed directly to accredited and contracted primary health care service providers and health establishments.”.
4. On page 20, in line 1, before “Emergency” to insert “Facility-based”.
5. On page 20, after line 3, to insert the following paragraph:

“(b) Mobile emergency medical services provided by accredited and contracted private health care service providers must be reimbursed on a capped case-based fee basis with adjustments made for case severity, where necessary.”.

CLAUSE 37

1. On page 20, from line 13, to omit subsection (1) and to substitute the following subsection:

“(1) A Contracting Unit for Primary Health Care is hereby established.”.
2. On page 20, in line 23, after “must” to insert “, amongst others,”.

CLAUSE 38

1. **On page 20, in line 44, to omit “Office of Health Products Procurement” and to substitute “Health Products Procurement Unit”.**
2. On page 20, in line 45, to omit “in” and to substitute “after”.
3. On page 20, from line 45, to omit “an Office of Health Products Procurement” and to substitute “a Health Products Procurement unit”.
4. On page 20, in line 48, to omit “Office of Health Products Procurement” and to substitute “Health Products Procurement unit”.
5. On page 20, in line 52, to omit “Office of Health Products Procurement” and to substitute “Health Products Procurement unit”.
6. On page 21, in line 13, to omit “Office of Health Products Procurement” and to substitute “Health Products Procurement unit”.
7. On page 21, in line 18, to omit “Office of Health Products Procurement” and to substitute “Health Products Procurement unit”.

CLAUSE 39

1. On page 21, from line 37, to omit paragraph (a) and to substitute the following paragraph:
“(a) be in possession of and produce proof of registration by a recognised statutory health professional council;”
2. On page 21, after line 39, to insert the following paragraph:
“(b) be in possession of and produce proof of certification by the Office of Health Standards Compliance; and”
3. On page 21, in line 41, after “criteria” to insert “accompanied by abudget impact analysis,”.
4. On page 22, from line 10, to omit “for recording on the Health Patient Registration System” and to substitute “on the prescribed information platform”.
5. On page 22, in line 12, to omit “national”.
6. On page 22, in line 26, to omit “as per the law”.
7. On page 22, in line 54, to omit “withdraws” and to insert “intends to withdraw”.
8. On page 22, in line 55, to omit “refuses” and to insert “intends to refuse”.
9. On page 22, in line 58, to omit “the decision” and to insert “its intention”.
10. On page 22, in line 60, to omit “a decision” and to insert “intention”.
11. On page 23, in line 8, after “establishments” to insert “and the periods of time applicable to health care service providers and health establishments where accreditation is withdrawn, not renewed or appealed”.
12. On page 23, after line 8, to insert the following subsection:

“(12) The Fund may grant conditional accreditation to a health care service provider or health establishment as prescribed by the Minister after consultation with the Office of Health Standards Compliance.”.

CLAUSE 41

1. On page 23, from line 58, to omit paragraph (a) and to substitute the following paragraph:
“(a) An accredited primary health care service provider or health establishment providing primary health care services must be reimbursed by the Fund in accordance with the prescribed capitation strategy.”

CLAUSE 44

1. On page 24, in line 46, after “Minister” to insert “after consultation with Cabinet”.
2. On page 24, in line 48, to omit “Board” and to substitute “Appeal Tribunal”.

CLAUSE 46

1. On page 25, in line 13, to omit “of the Board”.
2. On page 25, in line 15, to omit “Board” and to substitute “Appeal Tribunal”.
3. On page 25, in line 25, to omit “180” and to substitute “90”.

CLAUSE 47

1. On page 25, after line 28, to insert the following subsection:
“(4) The operation and execution of a decision which is the subject of an appeal is suspended pending the decision of the appeal.”.

CLAUSE 48

1. On page 25, in line 36, to omit paragraph (b).

CLAUSE 49

1. On page 25, in line 48, after “shifting” to insert “of”.
2. On page 25, in line 48, after “from” to insert “national government departments and agencies and”.

CLAUSE 54

1. On page 27, in line 13, after “discloses” to insert “confidential”.

CLAUSE 55

1. On page 27, in line 50, after “accreditation” to insert “and conditional accreditation”.
2. On page 28, from line 17, to omit paragraph (u).
3. On page 28, from line 43, to omit subsection (4).

CLAUSE 57

1. On page 28, in line 57, to omit “five” and to substitute “three”.
2. On page 28, in line 57, to omit “2017 to 2022” and to substitute “2023 to 2026”.
3. On page 29, after line 9, to insert the following subparagraph:
“(v) prepare for the establishment of the Fund as a Schedule 3A entity contemplated in section 9, including developing and implementing administrative and personnel related arrangements.”
4. On page 29, in line 11, to omit “four” and to substitute “three”.
5. On page 29, in line 11, to omit “2022 to 2026” and to substitute “2026 to 2028”.

Schedule

1. On page 31, in the second line of the second column, to omit “Control”.
2. On page 31, from the fourth line of the third column, to omit “in consultation with the Office of Health Products Procurement established in section 38 of the National Health Insurance Act, 2019” and to substitute “after consultation with the National Health Insurance Fund established by section 9 of the National Health Insurance Act, 2019”.
3. On page 31, from the fourteenth line of the third column, to omit item 1 (b).
4. On page 32, in the twenty-sixth line of the third column, to omit “and shall in a case to”.
5. On page 32, in the twenty-seventh line of the third column, before “which” to insert “and shall in a case to”.
6. On page 33, in the nineteenth and twenty-fourth lines of the third column, after “him” to insert “or her” and after “he” to insert “or she”.
7. On page 33, from the twenty-ninth line of the third column, to omit item 1 (a).
8. On page 33, from the forty-ninth line of the third column, to omit item 3.
9. On page 35, in the fourth line of column three, after “services;” insert “and”.
10. On page 35, from the twenty-first line of column three, to omit subsection (3) and substitute the following subsection:

“(3) Every inmate may be visited and examined by **[a medical practitioner of his or her choice and]** an accredited health care service provider, subject to the permission of the Head of the Correctional Centre [, may be treated by such practitioner, in which event the inmate is personally liable for the costs of any such consultation, examination, service or treatment].”.

11. On page 37, in the fourth line of column three, after ‘ ‘Act,’ to insert “1999 (Act No. 1 of 1999)”.
12. On page 38, after the thirty-second line of column three, to insert “(e) by the insertion in subsection (2) after paragraph (l) of the following paragraphs:”
13. On page 39, in the first line of column three, to omit “(e)” and substitute “(l)”.
14. On page 40, in the twenty-first line of column three, to omit the full stop and substitute “; and”.
15. On page 41, in the twenty-eighth line of column three, to omit “subparagraph” and substitute “subparagraphs”.
16. On page 43, from the first line to omit section 31B.
17. On page 44, from the thirty-second to thirty-third line of the third column, to omit “Office of Health Products Procurement” and to substitute “Health Products Procurement unit”.
18. On page 44, in the forty-eighth line of the third column, after “abuse;” to insert “and”.
19. On page 44, in the fifty-second line of the third column, after “abuse” to substitute semi-colon with a full stop.
20. On page 44, after the fifty-seventh line of the third column, to insert “(d) provide assistance to persons who establish substance abuse services”.

ARRANGEMENT OF ACT

1. On page 4, in line 8, to omit “Procedures” and to insert “Quorum, decisions and procedures”.
2. On page 4, in line 26, to omit “Disclosure of interests” and to substitute “Conflict and disclosure of interest”.
3. On page 4, in line 38, to omit ‘Office of Health Products Procurement’ and to substitute “Health Products Procurement Unit”

4. Expression of minority views

Rule 288 (3) (f) of the National Assembly states in its report the Committee must, if it is not a unanimous report—

- (i) specify in which respects and why there was no consensus, and
- (ii) in addition to the views representative of the majority in the committee, convey any views of a minority in the committee in order to facilitate debate when the report comes before the House.

Minority reports were received from the DA, EFF, IFP and FF-Plus as follows:

4.1. Democratic Alliance (DA)

Introduction

The Democratic Alliance (DA) unequivocally rejects the National Health Insurance (NHI) Bill. The DA has always been in support of universal healthcare, especially for the poorest of the poor, however a Bill of such nature cannot be haphazardly thrown together without proper and due consideration of all material facts and circumstances in which South Africa finds itself. Should this Bill pass, it will do exactly the opposite of what it is trying to achieve, bringing a total collapse of the healthcare sector and an ushering in of another form of state capture, with the State being the sole provider of services to the public. The DA thus is not able to recommend any amendments to be made to the Bill as the Bill as a whole fails in its entirety in both constitutionality and the ability to be practically implemented.

Grounds for Rejection

Impossibility of implementation

The Bill fails immediately on the basis that the provisions in the Bill simply cannot be implemented due to the many various reasons such as poor service delivery, lack of staff, lack of ambulances, the consideration that the poorest of the poor will not be able to meet the strict requirements of certain provisions in order to obtain healthcare, locations of services providers in rural areas and the very real threat of tender corruption, fraud and looting of the Fund.

Certificates of Need

The Bill makes vague references to certificates of need. However, whether expressly mentioned or not, certificates of need have been declared unconstitutional and are subject to constitutional scrutiny by the Constitutional Court still. Until such time as this has been done, these clauses in the Bill are unconstitutional and are such a material aspect to the Bill that they cannot be severed from the remaining.

Overwhelming powers given to the Minister

The Minister of Health is given unreasonable powers in the implementation and running of the Fund. The Minister essentially steps into the role of a CEO of sorts and is actively involved in the day to day running of the Fund which cannot be allowed to happen. If this were to happen, we would see a complete overreach of powers and influencing the decision of the board. For some reason, the Minister may also be involved in the appeals process. He should be playing no part in this process. The Minister also has powers to determine the price of healthcare services and has the ability to determine which service providers would be entitled to be paid over another. These broad powers are only asking for fraud, corruption and state capture to be allowed to run rampant. The Fund is supposed to be an autonomous entity, however in reality, it is an extension of the Minister.

The Minister is entitled to select the members of the Board as well as chairperson. The Minister should have no powers in appointments as this will be nothing more than cadre deployment which we have seen decimate every single SOE in South Africa. All appointments should be open and transparent and done by Parliament.

Ability to Fund Universal Healthcare

The Bill will not be able to realistically provide reasonable healthcare to all people in the current climate of South Africa. By removing the two-tier healthcare system, you will now be overloading an already overburdened public healthcare system. Currently, the Department of Health has billions of Rands in medico legal claims. If the entire health budget were to be directed to the Fund, it would almost immediately bankrupt the Fund and it would not have the ability to pay its service providers, let alone within 30 days of invoice, which all ANC government entities and departments are already failing to do.

Public hospitals already are suffering from lack of budget, understaffed, lack of equipment, beds, sheets, medical supplies and even electricity and computers in some hospitals. There is simply no way that the NHI will be able to provide adequate healthcare to people in South Africa if the basic infrastructure is not fixed first. In fact, the Minister of Health recently admitted that the public healthcare system would need approximately R200 billion to fix the current infrastructure before it can even consider NHI.

Accredited health care providers

The Bill provides that only accredited health care providers are entitled to provide medical services to people, by means of the Fund purchasing these services. However, the Council for Health Accreditation confirmed in the committee that they do not have the resources to inspect each health care service provider. This would certainly violate their right to their choice of occupation or trade. Additionally, of those who have been inspected for accreditation, the overwhelming majority of service providers failed in their accreditation due to a host of various issues. If they are not accredited, they will not be able to provide services. This applies to almost every single public hospital and the result of them not being able to provide services would be catastrophic. Additionally, if the government were to try and exempt these institutions and allow them to provide services, it would be unfair and unreasonable to those who have

been required to be accredited and any operation of these institutions would be *ultra vires* the Act (the Bill currently).

Centralisation of Powers from Provincial Authorities

The usurping of provincial powers and duties from the provincial health departments may be unconstitutional and violates the constitutional framework from which the provincial departments are entitled to operate. It is clear that the Department, in drafting this legislation, had not undertaken a proper impact assessment insofar as the relationship with existing health legislation is concerned.

Removal of Medical Aid Providers

The Bill will eventually remove the option of people from choosing whether to be a part of a medical aid scheme. This may pose constitutional challenges as it now affects a person's right to choose, freedom of association and, undoubtedly, the right to access to medical care. Currently, persons paying for medical aid have the choice of medical service provider or hospital and are almost guaranteed swift, immediate medical attention. If this Bill is enacted and there is even a slight delay in being able to provide immediate medical treatment, and any change in quality thereto, this would result in a breach of these persons rights in terms of the Constitution.

National Health Information System

The Bill makes provision for a database to gather all person's information relating to NHI. There are serious concerns of data breaches and breaches in terms of POPIA. There has been no clarification of what is being done to prevent any information being leaked or lost. Additionally, the practicality of maintaining a single database is unrealistic with many hospitals and service providers not even having access to internet, phones, or computers. How would they realistically capture this data until such time as there has been a complete overhaul of infrastructure in the healthcare sector.

Single Fund Purchaser

The Bill makes provision for the State to become the single purchaser of all medical services. There are no guidelines on how these services will be purchased or which ones will and will not be purchased. What are the criteria for a medical procedure being applicable to the fund. How would these decisions be made in real time and if refused, how long would a person wait while the appeals process takes its course and what happens if such a treatment is an emergency or one where a person is in complete pain but is not life threatening *per se*. There has been no confirmation as to how much each service will be purchased for and whether service providers would even accept these rates. If the rates are too low, we would see a major shortage of particular services because doctors would refuse to operate.

The Fund will determine how and what it funds and does not fund without any form of oversight. If the entire health budget were to be directed to the Fund, there would be wide scale corruption and theft and we would see a total collapse of the system.

District Health Management Office

DHMO will be established as a national component and will support and coordinate the provision of primary healthcare services at a district level. These structures effectively strip away the powers of provinces to finance, plan and district health services and allocate them to the Minister of Health. The DHMO will be a government component. This can only be established if the “prescribed feasibility study is conducted, and its findings recommend the establishment of such a component.” (Minister of Public Service Administration, 2007, section 10(7A)(1)). No evidence of such a feasibility could be found, however, apart from the appraisal of the 11 NHI pilots, which did not test health authority designs, or the implications of wide delegations allocated to public entities.

No framework is established that makes the proposed DHMOs accountable to the communities they will purchase services for. There is also no clarification of what kind of public structure a so-called contracting unit is. Given that they would have substantial delegated powers to procure health services.

Complaints Procedure

The Minister should have no need to be consulted in the complaints procedure of the Fund, this should be independent and based on the facts of each case. The Bill is vague in terms of the time periods in which complaints must be dealt with, especially where a medical procedure is pending upon the outcome of the complaint or appeal. The Minister is also in charge of appointing the appeals tribunal which removes any aspect of independence. It should be an independent appointment process.

Source of Funding the NHI

There has not been any form of feasibility study or test been done to determine the exact costing model and whether Parliament and Treasury are able to provide such funding without jeopardizing the quality of healthcare. Government has come out and refused to conduct any feasibility or social impact study post Covid-19 pandemic. We cannot use historical figures to determine whether we are financially able to afford it. In any event, even when studies were conducted in the infancy of this Bill, most failed the criteria measured. Treasury has also not committed to being able to fund in full, the NHI. The Standing Committee on Finance in the National Assembly has also not been briefed or deliberated on the ability to fund the NHI. This Bill cannot regulate how treasury disperses fund. These must be contained within a Section 77 Money Bill.

The NHI will supposedly be funded by additional taxes to employees, however, we cannot afford to overtax the working population, which is dwindling year by year. We will see a mass exodus of taxpayers, or civil disobedience if we are to levy more taxes upon them when they are already struggling as it is with the increased costs of living and lack of electricity. There is no mention on what happens to provinces' debt. In 2020/21, the Eastern Cape owed R921 million in medico-legal claims and an estimated contingent liability of nearly R39 billion in unresolved claims. Should the Fund be held responsible for this debt, how would this impact service delivery to the other provinces?

Conclusion

The above are just a handful of some of the concerns and reasons for the DA rejecting this Bill. It is clear that there is no affordability study to confirm whether South Africa could ever afford to fund NHI, which it cannot. If this is the case, then every other single point falls by the way side and the Bill becomes defective from the outset. A bill cannot be enacted where it cannot reasonably come into operation and practically achieve its intentions. There are a host of constitutionality issues which will be tested in the Constitutional Court when this Bill inevitably gets pushed through Parliament by the ANC majority.

The DA's only recommendation would be to completely scrap the Bill in its entirety and for government, political parties and civil society to work together to find a practical, and financially achievable way, of attaining universal healthcare. The DA thus can only reject this Bill in its entirety and does not support it.

4.2. Economic Freedom Fighters (EFF)

The National Health Insurance Bill, per definition, aims to ensure that the provision of universal healthcare access to quality healthcare for all South Africans is a reality as enshrined in the Constitution. Primarily, the intention is to recognize that everyone has the right to have access to healthcare services to which the state is responsible to utilise its resources and legislative measures to see this through. A national fund to this effect is established that will cater for the health needs of all persons and no one should be refused emergency medical care treatment in private and public healthcare facilities alike. When people visit healthcare facilities, there will be no fees charged to them personally because the NHI Fund will cover the costs of people's medical care in the same way medical aids do for their members in the private sector.

However, the NHI Bill does not mirror the organisational aspirations of a socialist country, as would be the position of the Economic Freedom Fighters. The NHI does not erase the two tier system as private hospitals will continue to function as private and the state will then pay for their service for citizens. The NHI in simple terms is the outsourcing of public healthcare to the private sector. The NHI does not respond nor address the inadequacies prevalent in public health facilities, issues of human resource, EMS, expansion of specialists in the public sector, infrastructural inadequacies of public hospitals and clinics and most importantly the quest to ensure a health system that is focused on primary healthcare and prevention.

The NHI is merely the transference of elite communities to be able to access private care that the state then pays from one national pool of funding whilst rural areas and townships in destitute and remote areas and provinces remain confined the very public healthcare that is dysfunctional as the referral system in the NHI Bill restrains people to their nearest healthcare facilities as the first point of reference. Furthermore, the profiteering priority of the private sector isn't addressed in the Bill. The EFF poses that all private hospitals be nationalised and one healthcare system be built without the inference of private care that prioritises profiteering over healthcare and wellbeing.

Noted below are the various aspects that are problematised and located as concerning according to the Economic Freedom Fighters;

Clause 5

- registration issues (registration, house address, exclusionary to those who aren't registered)
- No clarity provided on what happens to children borne to non NHI users.
- Issue of proof of residence – Bill fails to stipulate what occurs to persons who do not possess proof of residence. This is primarily a concern as millions of our people are confined in undignified informal settlements and subjected to homelessness. This clause therefore suggests an intolerance for persons affected to this effect.
- the Bill fails to make an accommodation for South Africans who are undocumented.

Clause 6

- 6.a. The requirement of proof of registration to fund or being a registered user to the fund before accessing healthcare is exclusionary. Nothing must keep people from accessing healthcare. Timeframe of registrations isn't stipulated, there isn't surety of this process being done diligently and efficiently either. There must be a provision for healthcare to still be accessible regardless of whether a person is registered or not.

Clause 7

- 7.1.d - is a limitation of possible health needs. A person can be referred to a primary healthcare facility, but that a person should first start there isn't always going to be possible. 1. There aren't primary facilities in all wards in the country. Some people are closer to hospitals than clinics and GPs. 2. Some illnesses are advanced or advance quickly to allow room for firstly a primary facility first as the first point of contact. No room created for severe cases that do not have the liberty of following through the specified process. 3. Some facilities aren't disability friendly infrastructurally and otherwise. 4. Failure to provide subsection that clarifies what the situation should be in relation to an issue being an emergency is a concern.
- 7.1.d.3. What happens in the instance of abuse against a patient at a health facility? A lack of referral shouldn't be an issue that results in a person not receiving access to healthcare. The Clause fails to stipulate what occurs in the instance that a person is refused care in one facility and opts for another facility without having a referral letter.
- Referral system overburdens the sector especially written referrals: termination of pregnancy- verbal referrals whereas the bill requires an alternative - there must be a clarity on this that prevents people being turned away on this account and refused healthcare because they don't have referral letters. This is already the case and affects our people negatively, more especially women attempting to access sexual reproductive health.
- Referral system is currently abused in the public sector with attempt to avoid care for patients in the instance a facility is overburdened. Bill is unclear on how unnecessary referral letters will be prevented that cause a delay in accessing healthcare.
- 7.5.d. there is no provision for adequate reasons for refusal of healthcare. 7.6 doesn't suffice as a means to resolve the issue so long as the person can't access alternative healthcare service at a different facility because of the referral system and awaiting outcome of lodged appeal. This is once again an imminent barrier in accessing healthcare as per need, which is cited as the primary foundation of the National Health Insurance Bill.

Clause 23

- 23,4 - opens room for more corruption, which currently regresses the quality of public healthcare in the current dispensation. No apparent means to counter corruption threats.

Clause 24

- 24,4,b - exclude immediate family members.

Clause 26

- 26,2 - lack of social sciences expertise. Socio political and economic aspects must be considered. Such expertise provides legitimate critic to limited view of science expertise. Must include legal expertise, social health expertise, geographic health expertise, political health expertise mainly because health issues, especially the monetary part is more political than not.
- The minister should not have a representative in this committee. Undue supervision and exerted power over numerous aspects of this bill that is problematic. Will limit discussions and contributions if there is a constant eye and voice from the minister's office that stifles engagements.
- Costing issues valid - possibility of these issues affecting existing legislation.

Clause 30

- Concern over this clause is that the ministerial power given to the Minister of Health is undue. A Minister cannot provide roles of Overseer, implementor, 'terminator' all at once at his /her discretion.

Clause 31

- The government of the day failed already on preventing wasteful expenditure; building administrative and technical muscle of NHI already chipping away at the state's ability to cater for other primary needs that have to do with implementing primary mandate and obligation of the department. Establishment of these committees, the meetings that will be held, accommodation paid for committee deliberations are already problematic as that is monetary value and muscle that could be utilised to build the state capacity of delivering basic health services, bettering infrastructure of existing health facilities and increasing work force of the public healthcare facility.
- It is very intentional that the minister is given this much power and it is purely political. That is what happens to cabinet members and an executive that pledges loyalty to Bill Gates who conceptualised step by step how this bill will be implemented and overlooks parliament and its role in oversight and holding executive accountable in small print as we see in such clauses such as clause 31,b.

Clause 32

- Clause 32 contradicts clause 31,2 which states Minister is the one that will delegate roles and functions to provincial departments in the context of the NHI despite that there's constitutional assertions and legislative assertions on this particular aspect. Second to this, there was an initial issue in the initial Stages of deliberating on the bill on the role of provinces and in fact there have been contributions from provinces that have raised concern of being ostracised and stripped of autonomy. Noting that the fund is handled centrally.
- 32,2b. Bill is unclear on where the legal autonomy of hospitals begins and where it ends, how it will affect litigation processes of the state and against the NDoH. Furthermore, the Bill is

unclear on the broader spectrum in relation to who carries the litigation costs of all hospitals, this including private hospitals.

Clause 33

- medical insurance/ low-cost benefit option – is wrongfully regulated by the Council of Medical Aid Schemes as it serves as insurance. The bill fails to make this depiction. This failure is analysed as allegiance towards medical aid schemes. The clause and the bill in its entirety fails to make a deliberation on what happens to persons who choose to not register to be NHI users. Bill further fails to clarify how unregistered persons will then access healthcare. Failure to register shouldn't be reason to lose the right to accessing healthcare.
- Sustainability - taking the money paid to medical aids and facilitating it as the state doesn't better the prospects of delivering sustainable healthcare. The money the government is aspiring for by taking away from medical aids, currently fails to cater for 10% of the population for an entire year as is.
- The Bill suggests an integrated and one healthcare system, which is misleading as the private sector doesn't cease to function as private facility. The retention of a two tier system remains the case even with the NHI fully rolled out.

Clause 34

- Clause fails to stipulate what system unregistered users will then utilise to access healthcare. This is primarily a concern as being registered is a primary requirement to accessing the fund and therefore accessing medical attention.
- No clear indication that the NHI will be an internalised system or outsourced. The Bill must clearly stipulate that the relationship the state will have with the private sector is equivalent to the tendering system.
- Bill fails to outline how the transfer of existing data onto the new system will take place and what the new system will therefore be.
- Bill unclear on how capacity will be internally increased, noting the current backlogs and issues with state capacity of building and sustaining information systems

Clause 35

- Implication of failure of registration of patients could possibly see exclusion from medicinal intervention. Unconstitutional repercussion for unregistered patients.
- Bill fails to outline on how unregistered users will purchase medication ordinarily purchased out of pocket or via medical aids. Unregistered users not covered. This will impact access to medicine for unregistered users as well, which is unconstitutional.
- Bill fails to deliberate on what the funding alternative will be in the instance that the NHI Fund pool of funds depletes.
- This clause releases government from financial burden of the NHI, which is unacceptable and will be problematic in future when fund can no longer cater for health needs and this clause is quoted in protection of this incapacity. More especially because incapacity can be caused by various reasons; mismanagement of funds, corruption, fraud, irregular expenditure. This clause serves as immunity for the state and not for the people and is a financial threat even for the private sector that prioritises profit and monetary gain at the centre of their contribution to service delivery.

- This essentially means in the event NHI funds run out, persons will be taken out from private facilities into public, as is the case when medical aids funds run out in the current *modus operandi*. This is a concern because the NHI has no intention of bettering public capacity and facilities, increasing the work force of the public sector, bettering the current infrastructural crisis
- What will be the return time of deciding the level emergency in the case the fund has ran out and, the waiting period must be clearly deciphered as this poses threat of permanent and elongated waiting periods, which may cost life in the case private institutions withhold services on account that the fund can no longer carry the financial cost.
- In the event the fund cannot cater for the application emergency services required in a nearby private facility, the bill fails to stipulate what will be done in response to this. In the event the private facility treats the emergency, and a decline of the service is the response from the fund, the Bill fails to stipulate who will carry the financial cost of rejected claims from the private sector for provided services. This will compromise users.
- 35.4.a Bill unclear on what the system of reimbursing private emergency services once the cap has lapsed will be and who deciphers severity levels of this capping of funds stated in the bill.
- Public sector EMS is currently dysfunctional. Bill fails to outline resuscitation of EMS services and what will be primary EMS provision; private or public.

Clause 36

- Noting infrastructural inadequacies, medicinal shortages, lack of healthcare worker force in public sector, what will be systematic method of resolving these barriers to primary healthcare when the NHI overtly states no intentions of bettering the public health system with the interest of primary healthcare, prevention and education (prevention and education are married to primary healthcare, however the ANC government is satisfied with a curative system). An in depth researched and possibility of this being a reality is a requirement.
- District based system is essential for any large project. The EFF made this recommendation to former Minister Zweli Mkhize in the early days of the covid pandemic which was sadly only taken up late and with minimal investment in accuracy and valid information.
- Capacity in SA questionable on district-based systems, covid pandemic highlighted the width of government will in investing in this aspect. Minor issues like verification of information had no way of being proven, and there was no systemic bucket of evidence that we could peruse regarding the numbers we got on daily basis and the burden on laboratories was evident and communicated. However, this did not lead the government to devise a fully-fledged system at district level. This will sadly be the case with the NHI as well if it was the case during the height of a global pandemic.
- The minister must explain this clause and the kind of intervention they envision to see this being a reality on a technical, scientific, and managerial level and how it will result in the guarantee of accessible, and quality primary healthcare, prevention and education as is the obligation and mandate of the NDOH that has never been realised since 1994, in fact for as long as I have been alive.

Clause 37

- Clause fails to outline the systemic numerical capacity of this unit.
- Clause fails to outline day-to-day roles deciphered to be the operational function of this unit.
- Clause fails to state accountability measures for the unit s to who the unit reports to and who supervises its day-to-day function.
- Subliminal Procurement, coordination and delivery is basically centralised in this unit which will pose an issue in accountability.
- This Clause highlights the overt tender system imminent in the bill. Promoting tender systems that will only see the public purse being ensued and the health needs of our people being compromised.
- Building state capacity for permanent systems or needs that will be permanently needed is the aspiration and priority.
- Outsourcing primary healthcare, prevention and education is equivalent to the NDoH making an admission that they have failed in their primary mandate and obligation. Which has always been the sentiment that we have shared as the fundamental reason behind the NHI.
- This clause is evidence and an admittance that the public healthcare sector has completely collapsed.
- Local and ward based public facilities should be established immediately, infrastructure prioritised, increase of the workforce in the public healthcare sector, and this aspect of the NHI should have been directed to coordinating the quest towards these aspects. The private sector will never be a legitimate vanguard of the healthcare of our people.

Clause 38

- Bill is unclear on who facilitates the purchase of medicines, medical equipment and other medical devices for persons, entities, health facilities, and other medical institutions who do not form part of the NHI as registered users and or service providers.
- The impression given is that the NHI will be an encompassing system for all persons and institutions, but isn't cognisant that choice will still suffice for registration processes and application process of potential service providers and health facilities and even users.
- Bill is unclear on what happens when facilities don't register as service providers. Bill is unclear on who will regulate the relationship between these two (registered and unregistered healthcare facilities). No clarity provided on the regulation of unregistered healthcare facilities.
- Bill is unclear on what occurs when registrations, and application for service providers isn't seen through on the end of the mentioned and what becomes the default method or system of accessing the basic rights to quality healthcare.
- Bill unclear on what happens to institutions or service providers who don't register to be providers for the fund (forced closure eg).
- Will persons not registered be forced to not access healthcare?

- If the private sector isn't nationalised as one of the strategic economic sectors, the state can never dictate to it its modus operandi, especially when there is room to not be a participant.

Clause 39

- OHSC is currently understaffed, and is unable to reach their targets over the past years on checking compliance, sending recommendations, and following up, as is with 400+ hospitals and 3863+ clinics; bill unclear on how will the OHSC then carry the burden of 610 more private clinics and 200 more private hospitals.
- 39.2.b This clause assumes that partnership or accreditation by the NHI will not be given to facilities that will not have reached all the requirements. Currently, just above 300 of 3800 clinics are considered ideal clinics in the country. Bill unclear on whether the NHI will reject the remaining public 3500 clinics will not receive accreditation from the OHSC or that the certification process will be different in the context of the NHI.
- 39.2. OHSC certificates are currently only valid for year, the work force of the OHSC is not capacitated enough to supervise and ensure implementation recommendations in public sector as is. They report this to the pc year in and out. Will OHSC capacity be increased for the NHI? What will be the financial implication of this as its not noted in the context of the bill? If it will be increased, to what number of personnel will this be and in contrast to hospital and clinic ratio?
- How will the NHI cater for the needs of the OHSC to be able to carry this responsibility which its currently incapable of doing because the state pleads poverty whenever the OHSC requests more funds to implement its role?
- The OHSC doesn't have the required capacity because like other health entities, it is at the brink of collapse, and sadly, unlike outsourcing healthcare to the private sector, this duty can't be outsourced as it will be equivalent to the private sector regulating and certifying itself.

Clause 40

- Repetition of clause 37 in relation to population needs assessment, service provider contracting and reimbursement - there needs to be a clear depiction of how these aspects will be handled instead of these roles being thrown at numerous aspects.
- Bill fails. To assert who exactly is responsible for population needs assessment within the context of the bill, who is responsible for service provider contracting and reimbursement, and who is responsible for fraud and risk management.
- 3.b. Monitoring plan and further budget for purchasing of quality personal health care services based on need, as per the clause asserts, cannot be done with the current information at disposal.
- This information isn't inclusive of persons who wanted healthcare services but couldn't afford it, not inclusive of information of persons whose medical aids funds ran out, and sadly is a limited view of persons as its only limited to the current provision of private sector clients who don't even make up 15% of the population.
- 3.c.d.e.f. is not feasible as Monitoring the stated aspects isn't encompassing as persons in the private sector have liberty to change facilities, to change doctors, to move from private sector to public, to change specialists, to adhere to medical aid

jurisdictions pertaining to where and from whom they get services based on cover allowances, and to revert back to the public sector.

- The operational system devised for this clause is thus too simplistic for the nuanced healthcare system currently at play. A more scientifically oriented system would be required.
- This clause once again serves as evidence as lack of political will to address the true and real healthcare needs of our people but as a means to flood money into the private sector, weaken the public sector, and further make a cash cow through the various corruptible aspects of this bill as a whole.

Clause 41

- Clause fails to address additional mechanisms of payment are being spoken of and what is the surety that these will adhere to the limitations of the law if the clause doesn't overtly state.
- 41.2. How is accreditation a requirement for reimbursement if there are clauses like 37 that state that accreditation is central to the process of even beginning formulating a state and service provider relationship? Does this mean these clauses regarding accreditation being central to agreements can be overlooked? And in which instance will this be allowed? The Clause makes no attempt at clarifying these contradictions.
- 41.2. and 41.4. Clause fails to assert if accreditation be scrutinised on a claim-to-claim basis or on a. Contractual yearly basis. This directly impacts the OHSC and its capacity thereof.
- There is no process outlined on the determining factors of retaining accreditation throughout the year, as accreditation tenets can be flouted by health facilities, a facility can be compliant today, and non-compliant tomorrow.
- In the instance that accreditation process is delayed by the state due to incapacity (we have noted OHSC capacity issues above), corruption, fraud, clause fails to outline what will be the means to decipher those circumstances and what protection do the private facilities you will be outsourcing from have from the failure of the state to see the end of their stick.

Clause 42

- 42.1. this particular aspect is lacking a breakdown of severity in cases and what would prove a reasonable time. This is problematic as its the current status quo, and numerous persons are subjected to health decay because there isn't room to decipher complaints based on severity (be it health emergency severity, and or financial implication severity on the part of the service provider).
- 42.3. no description on what happens in the instance that the fund hasn't communicated the outcome of the investigation within the stipulated time.
- 42.4.c. no clarity on whether the refusal of accreditation to be a part of the fund equal that the facility is rendered non-functional.
- 42.2. In the instance that a complaint is extremely severe and cannot be conclusive in 30 days (criminal case), clause doesn't outline what is the method and or system.

Clause 43

- An appeal period should be scrapped. Access to information, especially with the department of health, rarely arrives to specified persons on time. Poor people should be considered in relation to accessing legal recourse. Even the current legal recourse available for the poor isn't as effective and accessible as it's meant to be.
- More so access to legal advice isn't an immediate reality for majority of our people in the country including the middle class who survive from hand to mouth and have no room of financing legal issues that may need legal advice and assistance. This shouldn't be a threat in regard to attaining justice for their healthcare grievances
- The limitations of the law cannot be cited as possible barrier as regulations and laws can be amended to make room for this liberty like with other laws that are meant to be amended to make room for the clauses of the NHI Bill
- There should be no rush in resolving the health grievances, especially users. Particularly when it comes to appeals.
- South Africa has a history of gross violation of human rights which is protected by such clauses. An example is the forced Sterilization debacle. Majority of the victims of forced Sterilization only found out they were violated years later and therefore couldn't do the formal application of negligence as the law only makes room for such cases to be reported within three years.
- It's upon this premise and precedence that this clause must be amended and make room for timeless appeals. The point of this aspect is to render justice, not to create an opportunity to refuse health justice to our people. More so the poor people.

Clause 44

- 44.1. Centralisation of power in ministers' office a recurring tenet and issue.
- The appeal board and all the other aspects mentioned in the duration of these deliberations should be noted as such; that the portfolio committee of health should be involved in the process and then recommend persons from a variety of possible candidates to which the minister can then make his decision.
- 44.3.c. Reasons for non-renewal should be stated, more so as this clause gives minister undue power and thus weakens transparency and partiality of appeal tribunal.
- 44.3.b. terms of reference do not cater for "good cause" as a term and therefore the terms relating to the meaning of good cause should be stipulated in the terms of reference as it's a recurring concern. A good cause in relation of termination of a board member should not be an encompassing term more so in a bill that exclusively gives minister so many powers and excludes body that is meant to hold the minister accountable, that is the pc of health and parliament.

Clause 46

- Records of the decisions of the board must be kept indefinitely. ICT system for this purpose must include this aspect.
- Forced Sterilization case reference as in clause 44 submission

Clause 47

- In the case that the appeal is unfavourable to user that is poor or financially incapacitated to access Supreme Court assistance, bill unclear on accessing justice to this effect.

- This clause and the structure of the above 3 clauses will cause a delay and eventually a denial of justice to poor people.
- This especially noting the appeal cut off dates stipulated in the bill itself on the above clauses.

4.3. Inkatha Freedom Party (IFP)

We as the IFP we vote yes on the issue of NHI.

4.4. Freedom Front Plus (FF-Plus)

1. Refugees and Asylum Seekers

In Section 4 (1)(C) and Section 4 (2)(3), the National Health Insurance (NHI) Bill states that refugees, asylum seekers or illegal foreigners and children of asylum seekers or illegal migrants are entitled to basic health care services. However, Section 28 (1)(C) of the Constitution of South Africa does not make provision for them, only for South African citizens. In addition, The Refugees Act, no. 130 of 1998 as published in the Government Gazette on 2 December 1998, states under Section 27(b) that a refugee "enjoys full legal protection, which includes the rights set out in Chapter 2 of the Constitution and the right to remain in the Republic in accordance with the provisions of this Act".

Chapter 2 of the Bill of Rights, however, under Section 27(3) only states that: "No one may be refused emergency medical treatment". This section does not make provision for government or the Minister of Health to put forward that the NHI Fund must provide health care services, as determined by the Benefits Advisory Committee, to refugees but must only supply emergency medical treatment to refugees.

Emergency medical treatment simply entails the following: The sudden and, at the time, unexpected onset of a health condition that requires immediate medical treatment and/or an operation. What qualify as and require emergency care are life-threatening emergencies, such as a heart attack or serious head injury, or an illness or injury that does not appear to be life threatening but cannot be left untreated and, thus, constitutes an emergency.

Thus, the government's argument that refugees, asylum seekers or illegal foreigners and children of asylum seekers or illegal migrants are entitled to basic health care services is null and void.

The health care services, as the national government and the Minister of Health want to implement it for refugees, asylum seekers, illegal foreigners and their children, will be financed by South Africans while they are the ones who are supposed to get the medical treatment, they deserve instead of these people who are migrating and fleeing to South Africa and draining the resources that South African citizens urgently need.

2. NHI-accredited Primary Health Care Facilities

In practice, Section 4 and 5 of the Bill will prove to be problematic as a patient will not be able to see the specialist or doctor of his/her choice before a patient is registered at an NHI accredited primary health care facility and the facility refers the patient to a specialist or a doctor. It is the view of the FF Plus that this Bill clearly contravenes Section 27 of the Constitution which explicitly states that: (1) Everyone has the right to have access to (a) health care services, including reproductive health care, and (3) no one may be refused emergency medical treatment.

On the 29th of August 2019, the Minister was unable to provide any clear answers when questions were put by FF Plus member of the Committee regarding the NHI Bill, particularly with regard to how the registration process of members on the NHI will work and how this database will function at the current state hospitals and how long it will take these institutions to implement the electronic patient database at state hospitals. It was reported in the media on the 21st of July 2019 that the Department of Health stated that it already has more than 42 million people on its register of patients for the NHI. These names were not obtained from hospitals, clinics or other medical institutions but it is a copy and paste register from the Department of Home Affairs Registry of South African citizens.

3. Total Cost of NHI

In addition, it is still not clear what the total cost to get the NHI up and running by 2026 will be and if South Africa can afford the implementation of the NHI. The effect of the NHI on the economy is a great matter of concern because with the tabling of the Bill in Parliament, the Johannesburg Stock Exchange already suffered losses of nearly R14 billion. A question was put to the President in Parliament regarding these losses, the President replied by saying that he regrets the losses but that people who are against NHI are against transformation. The fact that the Minister stated in the Committee meeting on the 29th of August 2019 that "no new money is used to set up the NHI" is very alarming.

Economists have predicted that the NHI will cost the government R256 billion in the 2025/26 financial year at 2010 prices. Therefore, it is a great concern that the economy will not be able to fund the NHI in the future.

Neither the Minister of Health nor the government or the Department of Health was able to give any indication of the financial implication of the NHI boards on taxpayers' pockets. No indication of any sort could be provided with regard to how the remuneration of:

- the eleven members of the NHI Board,
- the Chief Executive Officer,
- the Chairperson,
- the Deputy Chairperson,
- the Technical Committee,
- the Benefits Advisory Committee,
- the Health Care Benefits Pricing Committee, and
- the Stakeholder Advisory Committee

will be funded or how large the remuneration package will be per annum, what sort of benefits it will include and how much it will cost the taxpayer to have these people serving on the

respective boards. The number of members who will serve on the Technical Committee, the Benefits Advisory Committee and the Stakeholder Advisory Committee is also still not known. In Chapters 4, 5, 6 and 7, the Bill merely stipulates that 16-24 members will serve on the Health Care Benefits Pricing Committee. Thus, it remains unclear how many members in total will serve on all of the abovementioned committees and at what cost per annum.

4. Medical Aids, Private Hospitals and Doctors

The fact that it is, thus far, still not clear what the role and functions of medical aids, private hospitals and private doctors will be under the NHI raises many red flags. There is a very real possibility that the NHI will have such a negative effect on the medical industry that doctors will hold the view that they do not have to be available on a 24/7 basis for the reason being that the government now pays them a "salary" instead of the current situation where they work very hard, not only for their own income, but also to serve the public. We are concerned that doctors and other role players in the medical field will look for better opportunities under better circumstances elsewhere and even abroad. This will surely have a detrimental effect on the South African economy.

It is also not clear what impact or effect the NHI will have on Chapter 3, Section 12 of the Medical Schemes Act, no. 131 of 1998. The impact the NHI will have on the future role of these medical schemes and their staff members as well as the funds that are currently being held in reserve in these medical aids' bank accounts and what will happen with these reserve funds all remain unknown. There is also a question mark hanging over the assets of these medical aids under the NHI.

Government must take note that South African doctors strongly oppose the NHI as they have been quoted saying that they "would not support the legislation in its current format as it would lead to large-scale corruption and that almost 40% of doctors would emigrate if a universal health care system was implemented" - IOL News, 2 January 2020. The South African Medical Association, which has a membership of 17000 doctors across South Africa, stated that as an organisation it cannot support the NHI Bill as it would create a monopoly in the health care sector. According to SAMA, the NHI will open up its structures to large-scale corruption.

A great cause for concern is that the NHI will seriously restrict the functioning and survival of the 80 registered medical aid companies in South Africa. With our country's alarmingly high unemployment rate, this is a matter of great concern. At present, a total of 9,4 million people are members of a medical aid and, thus, the job creation in this industry alone is significant. If the NHI Bill makes the existence of medical aids superfluous, the great concern is that the current unemployment rate will rise even higher seeing as these medical aid companies will have to retrench personnel. Thus far, government has not been able to indicate how these personnel can be accommodated under the NHI so that they do not merely become part of the unemployment rate statistics. What exactly the role and functions of the current pharmaceutical companies and the distributors of medicine as well as private chemists will entail under the NHI has not yet been defined either. The current shortage of medicine and hospital equipment at state hospitals and clinics will not be easily resolved and, thus, the situation will only get worse.

With the unemployment rate currently at 34.9%, as in the 3rd quarter of 2021 , the concern is that the NHI will seriously restrict the functioning and survival of the 80 registered medical aid companies in the country and that will cause the unemployment rate to rise even higher seeing as these medical aid companies will have to retrench personnel. According to statistics released in October 2019, the medical aid companies provide medical care to 4 039 705 members and 8 916 695 beneficiaries who are currently not a burden on the public health care sector. On top of that, many specialised medical professionals will opt to leave the country and that will have a further negative impact on our economy.

The government's attempt to nationalise health care services and to take full control of the administration and management thereof will mean that the NHI will ultimately follow in the footsteps of Eskom, Transnet, Denel, the SABC, SAA and many more. The NHI will merely make it easier to steal taxpayers' money. The National Health System in Britain, a developed country, is not even functioning properly. In a British newspaper, the Daily Mail of 12 August 2019, it was reported that the system is collapsing due to a staff crisis and that patients had been waiting for three weeks just to get an appointment with the doctor. At that time, some of the doctors had had a waiting list of more than five weeks.

5. Effect of NHI on the Economy

At this stage, no thorough assessment has been done in order to see what the effect of the NHI will be on the economy. With the tabling of the NHI Bill in Pretoria by the Minister of Health in 2019, the Johannesburg stock market already reacted negatively with a loss of R14 billion on the said day. In a question submitted for written reply to the Minister of Health by the FF Plus MP in the National Council of Provinces on the 23rd of August 2019, question no. 60, internal question paper no. 09, the party enquired of the Minister "whether his Department received any concerns from the National Treasury regarding the implementation of the NHI; if so, what were the concerns; whether his Department considered such concerns; if not, why not; if so, what are the relevant details; whether his Department consulted with the Premiers of the provinces regarding the implementation of the NHI; if not, why not; if so, what are the relevant details?"

The Minister of Health's answer to these questions was as follows: "So they, National Treasury, have been part of the policy development and raised many concerns in the process which was dealt with by the Ministerial Committee or through the interdepartmental processes."

In his answer the Minister stated that "the concerns raised by Treasury relate to the following areas: a) the extensive nature of shifting provincial functions and funds to the national sphere needs adequate planning and time to implement, (b) clarity regarding the location of each function list in the National Health Act. (c) provisions that contravene the Public Finance Management Act and Division of Revenue Act. (d) the NHI Fund as a direct charge against the National Revenue Fund, (e) the Bill should provide greater detail relating to the transitional phases until full implementation of NHI for medical schemes to understand what their complementary role will be in the future, (f) the financial implications relating to the various policy proposals."

The greatest threat to the success of the NHI is the government itself as over the past 26 years, it has repeatedly shown that it is utterly unable to govern or manage South Africa. The NHI is just another way in which the government plans to get its hands on taxpayers' money and it is hard to believe that the money will not eventually end up in the pockets of corrupt cadres.

The South African government has repeatedly shown that it cannot be trusted with taxpayers' money.

The FF Plus foresees that the NHI will have an extremely negative impact on South Africa's economy. One clear indication of this is that when the Bill was tabled in Parliament during August 2019, the Discovery Group's shares fell with 8,5% directly after the Bill was tabled. The very next day, the same

Group's shares fell with another 8,4%. Therefore, the NHI Bill is already having a detrimental effect on South Africa's economy and we are worried that the economy will suffer great damage due to this new notion of nationalising the country's health care services.

The FF Plus is seriously concerned about this as the South African government wants to implement a system that is obviously not well thought through. If the system is causing problems in a country like Britain, one cannot help but wonder what will happen in South Africa where poor administration, mismanagement and corruption are at the order of the day.

In addition, it was not only the Discovery Group's shares that fell on the Johannesburg Stock Exchange. On the 13th of August 2019, an amount of R14 billion was lost in terms of the value of health care shares on the Exchange. This sharp decrease in the value of shares occurred due to the uncertainty and negative sentiments surrounding the Bill. The companies that suffered the greatest losses on that day are Afrocentric Health, Momentum Shed, Discovery and Adcock Ingram. This trend could spill over to other listed health companies on the Johannesburg Stock Exchange and that will drastically weaken South Africa's economy. It could also put the future of the employees of these companies in jeopardy seeing as employees may have to be retrenched if share prices keep plummeting. This will have a ripple effect as employees will not be able to pay their monthly debt instalments and then financial institutions will suffer great losses as well.

The NHI Bill must be abolished in the interest of South Africa so as to prevent any further financial losses in the economy. In Ireland, an attempt to implement a similar system was abandoned after just four years because the costs related to it were just too high.

South Africa cannot afford to sustain any more damage to the economy and its already struggling health care system. The Minister of Health's promise that the NHI will not take the same risks as Eskom is vague and not reassuring. The Minister made this statement during the Hospital Association of South Africa Conference in August 2019 in Cape Town. Statements like this not only aim to mislead the public, but they also do not divulge the whole truth to South Africans. An explanation of how the government will ensure that the NHI does not suffer great financial losses and how government plans to manage this Fund to prevent corruption must be provided. It must be noted that during the same week, it came to light that corruption had occurred with the South African Police Service's medical aid, Polmed, as an amount of R15,7 million was unlawfully allocated to the Fund's board of trustees over a period of three years. The board of trustees had awarded themselves salary increases.

The NHI will also have a board of trustees which will function in terms of the legislation of the Public Finance Management Act. There exists a very real possibility that this board of trustees will follow in the footsteps of Polmed's board of trustees and neither the Minister of Health nor the President can guarantee that corruption will not occur in the NHI.

6. Financial and Fiscal Commission (FAFC)

During a meeting of the Portfolio Committee on Health held on the 9th of October 2019, the Financial and Fiscal Commission (FAFC) raised many concerns regarding the NHI. According to the FAFC, there are various progress, budget and policy issues. The FAFC stated that the rolling out of the NHI has

been on the budget programme since the release of the Green Paper in 2011 and after that two White Papers have since been released followed by the NHI Bill in 2018. According to the FAFC, a new NHI grant was introduced in 2012 to finance 11 NHI pilots with an initial three-year allocation of R1 billion. They said that the NHI grant "encountered teething underspending challenges resulting in allocations reductions (R192 million in 2013 MTEF) and the introduction of an Indirect Health Insurance Grant."

They explicitly stated that "planning was problematic from the beginning." According to the FAFC, the NHI pilot grant was intended to test the feasibility of the new delivery models which include the district and ward-based clinical team and primary health care and the contracting of health practitioners. However, they stated that the pilot has since "produced mixed results and it did not cover the private sector". During these pilots, the following problems occurred:

- health patient registration system was rolled out,
- the workload of "staffing need not met due to post freezing",
- the target to refurbish 140 clinics' infrastructure was not met,
- the stock visibility system was hampered by connectivity problems,
- the contracting of private doctors proved to be expensive after only 350 doctors were contracted,
- the full implementation of NHI is still years ahead, but the Fund is scheduled to be operational by 2026,
- the 2017 budget announced the establishment of the NHI Fund in 2017/18 where only R64 million was allocated in 2018 and no additional funding has since been announced, and
- several hurdles lie ahead and must be overcome before the NHI Fund can come into operation and that the 2026 timeline is "too short a target to complete all the necessary steps".

According to the FAFC, approximately nine activities remain outstanding on the progress of the NHI. They are the following:

- the establishment of an operational and administrative capacity,
- the development of health information systems,
- the function shifts and rearrangement of funding flows,
- the costing,
- health care benefit design,
- the design of a provider payment mechanism,
- the setting-up of new delivery structures and committees, and
- contracting and testing.

They outlined that "the implementation plan is going to need rigorous planning and sequencing". They also stated to the Committee that the NHI grant has undergone numerous iterations since its inception in 2011. They added that "the continuous repurposing of the NHI grant is worrying given the imminent introduction of the NHI Fund and that the baseline of allocations for the NHI grants has been 'reduced drastically' and that it 'inadvertently delays implementation'".

Despite the changes that were made to the medical tax credits, there is no proposal to integrate the multiple NHI streams to establish the Fund. The FAFC stated that budget allocations to the NHI continue on the same trajectory of a piecemeal and incremental approach, thus, the funding results in unrelated

outputs. The reason for this being that old programs were repackaged under the NHI funding regime. They also warned that "constant iteration of NHI funding create implementation uncertainties".

Certain NHI policy issues, which are fundamental to the successful rollout of the NHI, also came to light. The following remain outstanding:

- the role of provinces remains unclear,
- how funds will flow between the NHI Fund, the provinces, the districts and private service providers,
- how the financing of health infrastructure will take place,
- the ownership structure of public health care facilities,
- intergovernmental relations and the local government fiscal framework accountability arrangements,
- distributional equity of contracted service providers,
- the implications for central procurements under contracted service providers and
- the rationalisation and function of the payroll under limited delegations.

The FAFC report further stated that according to findings by the Health Market Inquiry, the Department of Health has "not been playing its regulatory role as required by law". The FAFC is adamant that the recommendations that are made in the Health Market Inquiry "should be aligned to the proposal made in the NHI Bill" and that the functions of the Supply Side Regulator for Health Care must overlap with some functions of the committees to be established in terms of the Bill, e.g., the Benefits Pricing Committee and the Contracting Unit for Primary Health Care.

The FAFC warned that national and provincial treasuries should develop some sort of framework and / or criteria for determining serious financial strain with clear measurable financial and non-financial factors that, according to them, can be monitored, reported and used to trigger automatic fiscal adjustment. The FAFC also recommended that the National Treasury and the Department of Health should allocate part of the 2018/19 Medium Term Expenditure Framework (MTEF) health infrastructure allocations to gradually set-off expenditure accruals which have arisen from "unavoidable demands for which allocated budgets were depleted." The Commission also warned that the National Treasury should ensure that the framework for health infrastructure conditional grants must allow for flexibility during periods of protracted fiscal constraints in order for provinces to re-orientate their package of available capital allocations towards maintenance and that health reforms must not undermine the integrity of the intergovernmental relations and the local government fiscal framework.

The FAFC issued a very harsh warning that health spending is consistently positive and exhausted but output and outcome performance show mixed results and that Parliament should focus its oversight efforts on under-achieved performance targets where there has been 100% expenditure against the budget. NHI grants should be specifically focused on reforms that advance the implementation of the Bill. Furthermore, the problems regarding the intergovernmental relations and the local government fiscal framework institutional arrangements must be resolved before "large budgetary commitments are made to the NHI."

It is the view of the FF Plus that the Portfolio Committee on Health, the Minister of Health, the Minister of Finance and the President need to hear and pay attention to the concerns and recommendations put forward by the FAFC. They are independent and they make valuable recommendations. It seems to us

that there is a communication gap between the Department of Health, the FAFC and the National Treasury. The FF Plus pointed out in the Committee meeting that the Committee needs to thoroughly review the problems regarding the NHI before the public participation process can commence. The infrastructure of existing hospitals, for example, must be attended to before new hospitals can be built.

7. Is NHI Sustainable or Not?

The NHI system is not sustainable. With the unemployment rate currently at 34.9%, as in the 3rd quarter of 2021, and nearly 30 million South-Africans living on state grants, together with a population of approximately 58 million people, this system cannot be a tax-funded system. The simple reason for this is that the economy is declining year after year and, thus, more and more people are losing their jobs and some even end up being homeless and as a result, the income tax base is getting smaller. The percentage of people who have been unemployed for a year or longer has increased with approximately 60% over the last ten years. It is a clear sign that South Africa's economic decline is brought about by poor governance and reckless policy directions. These are the reasons why the number of despairing jobseekers, which has increased with 62000 from the third to the fourth quarter of 2019, is still on the rise. Poor economic growth and government policy, like expropriation without compensation, the NHI Bill, poor service delivery, load shedding and the collapse of local government are all factors contributing to the unemployment crisis in South Africa.

The Minister of Health himself admitted during the Committee meeting held on the 29th of August 2019, that "the economy is a matter of concern."

Chapter 10, Section 48, of the Bill stipulates the sources of funding for the NHI Fund and in terms of Section 49(2)(i), the Fund is entitled to general tax revenue, including the shifting of funds from the provincial equitable share and conditional grants into the Fund, as well as (ii) reallocation of funding for medical scheme tax credits paid to various schemes towards the Vffunding of the NHI and (iii) payroll tax and (iv) surcharge on personal income tax. In light of the report issued by the FAFC on the 9th of October 2019, is it clear that there is still no proven funding model for the NHI.

8. Stability in South Africa

South Africa is not politically and economically stable. State hospitals in South Africa are not up to standard and many problems are experienced on a daily basis. The public health care sector has already collapsed. There is no guarantee from the South African government that the NHI system will be a system without any corruption. The NHI will follow in the footsteps of all the other state-owned enterprises, like the SABC, SAA, Denel, Eskom, Prasa and Transnet.

The NHI will be the sole cause of health care services in South Africa, both in the public and private sectors, collapsing and leaving nearly 58 million people without medical treatment.

9. Auditor-General

The Auditor-General reported that during the 2018/19 financial year, the Department of Health underspent with an amount of R1 billion. The Auditor-General also reported to the Committee in October

2019 that state hospitals do not make optimal use of their medical equipment. At the Rob Ferreira Hospital in Mpumalanga, a new CT scanner and Fluoroscopy unit, worth R13,2 million, have not been used since 2015. The Letaba Hospital also owns a new CT scanner and Fluoroscopy unit, which have not been used since 2015. At the Chris Hani Baragwanath Hospital in Gauteng, a C-arm unit is not being used optimally. There is equipment that require repairs at the Pelonomi Hospital in Bloemfontein. There are infrastructural deficiencies at the Wentworth Hospital in KwaZulu-Natal. At the RK Khan, Northdale and the Moses Katane hospitals, there is defective radiology equipment that has not been removed from clinical areas and the condemnation process is seriously backlogged, in some cases, as much as nine years. There is a lack of secured and controlled access to all filing and storage areas of medical records in Gauteng, Mpumalanga, the North West, Northern Cape and Western Cape. There is a lack of adequate infrastructure to ensure the safe storage of records in the Eastern Cape, Free State, Gauteng, KwaZulu-Natal, Limpopo, Mpumalanga, the North West, Northern Cape and Western Cape.

In addition, the policies and procedures for the archiving and disposal of medical records have not been properly implemented in the Eastern Cape, Free State, Gauteng, KwaZulu-Natal, Limpopo, Mpumalanga, the North West, Northern Cape and Western Cape. There is also a lack of ongoing maintenance of the current infrastructure as a result of ineffective condition assessments conducted at all health facilities. Furthermore, approved maintenance plans or policies for the maintenance, refurbishment and / or rehabilitation of the health infrastructure in the Free State, Eastern Cape, Gauteng, Limpopo, Mpumalanga, Northern Cape, North West and KwaZulu-Natal are also lacking. Another matter of great concern is the inadequate training provided to staff on the IT aspects of pharmaceutical systems.

10. Shortage of Medicine

The shortage of medicine at state hospitals and clinics is a matter of great concern and a serious problem that must be addressed before the NHI can be implemented. In a written question sent to the Minister of Health on the 18th of October 2019, question no. 1189, an FF Plus Member of Parliament in the National Assembly asked the Minister whether any accounts for medicines of provincial hospitals and clinics are currently in arrears and if so, which provincial state hospitals and clinics, for how long each account has been overdue and what are the outstanding amounts in each case and what are the reasons for each account being overdue? The Minister responded: "Yes, there are provincial departments that currently have accounts that are overdue in the current 2019/2020 financial year." He went on to state that clinics and hospitals order from suppliers although accounts are reflected at a provincial level: "All provinces have accounts with suppliers that are over 30 days." The Minister reported that the following provinces have the following amounts outstanding to suppliers for more than 30 days, as at 21 October 2019:

Eastern Cape	R372 390 458
Free State	R122 646 385
Gauteng	R576 561 312
KwaZulu-Natal	R543 006 083
Limpopo	R140 390 236

Mpumalanga	R206 048 207
North West	R315 572 056
Northern Cape	R137 365 307
Western Cape	R294 001 159

The Minister also stated that the "budget allocations for medicines in the provinces are insufficient to meet the demand for the financial year. Provinces often have to first pay accruals from the previous financial year at the beginning of the next financial year." The Minister said that this causes a cash-flow problem leading to "delayed payment." He also added that in some cases, there are administrative problems where invoices do not reach the provincial finance department.

In response to a follow-up question from the FF Plus enquiring whether the supply of medicine to provincial state hospitals and clinics has been suspended by manufacturers due to overdue amounts still owed by the provincial state hospitals and clinics and which ones are affected, the Minister answered that the following provinces' accounts were suspended by the following suppliers:

- North West: Accord, Adcock Critical, AstraZeneca, Gulf and Unitrade.
- Eastern Cape: Pharmachem.

The Auditor-General also reported to the Committee that there is an overall lack of service delivery in state hospitals and clinics due to mismanagement and maladministration. The Department of Health's vision and mission have been completely destroyed.

11. NHI Pilot Projects

NHI pilot projects have been conducted across South Africa according to a report published by G: ENESIS entitled *Evaluation of Phase 1 implementation of interventions in the National Health Insurance (NHI) pilot districts in South Africa. NDOH10/2017-2018. Final Evaluation Report July 2019.*

According to this report on page 12, the ten NHI pilot districts were made up of one district in every province except KwaZulu-Natal, which had two districts. The KwaZulu-Natal province, however, also included a third district which was funded through the provincial government. According to the report, these districts were intended to become sites for innovation and testing throughout the implementation of Phase 1. The pilot districts included: OR Tambo in the Eastern Cape, Thabo Mofutsanyana in the Free State, Tshwane in Gauteng, Umgungundlovu and uMzinyathi in KwaZulu-Natal, Vhembe in Limpopo, Gert Sibande in Mpumalanga, Pixley ka Seme in the Northern Cape, Dr. Kenneth Kaunda in the North West and Eden in the Western Cape.

On page 14 of the report, the following worrying remarks are made: "However the interventions also faced a number of challenges, and, to varying degrees, these factors hindered their success: inadequate planning, lack of resources, inconsistent communication, a lack of coordination where necessary and insufficient mechanisms to monitor progress to ensure course correction."

On page 14 and 15 of the report, the following intervention challenges are explicated:

WBPHCOT (Ward-Based Primary Health Care Outreach Team)

- "Teams often lacked the envisioned team composition"
- "Data collection was insufficient"
- "Insufficient funds for transport and equipment"

ISHP (Integrated School Health Programme)

- "Lack of data to support the effectiveness of the referrals"
- "Lack of feedback mechanisms"
- "Lack of sufficient equipment, such as measurement scales"
- "Lack of prioritisation and targeting of learners"

GP Contracting | General Practitioner

- "Inadequate monitoring of these GPs caused some challenges during implementation"
- "Unforeseen contractual challenges during the implementation of this intervention resulted in GPs having substantially higher expense claims than expected"

ICRM (Ideal Clinic Realisation and Maintenance Model)

- "The changing manual and frequent change of standards which made it difficult for managers to keep up and resulted in frustration among them"
- "Ideal Clinic Realisation and Maintenance Model (ICRM) limited flexibility and the ability for managers to adapt it"

DCST (District Clinical Specialist Team)

- "The team composition, which often lacked critical specialists, limited their ability to provide the envisioned training and support structures"
- "The lack of gynaecologist and paediatricians meant that District Clinical Specialist Teams (DCSTs) were not able to adequately improve child and maternal health as envisioned"
- "Specialists ... unable to provide adequate support"
- "The DCST model is a costly model and stretches the limited specialist resources in the public sector"

CCMDD (Centralised Chronic Medicine Dispensing and Distribution)

- "Change of service providers threatened the interventions continuity"
- "Lack of sufficient integration between Centralised Chronic Medicine Dispensing and Distribution (CCMDD) pick-up points and facilities resulted in inadequate tracking of patients between the two systems"

HPRS (Health Patient Registration System)

- "Poor connectivity at some facilities and challenges with hardware"
- "Lack of human resources and lack of capacity"

SVS (Stock Visibility System)

- "Lack of reliable internet connectivity and hardware"

- "Minimal number of available pharmacists and pharmacy assistants" Infrastructure
- "Lack of planning and capacity"
- "Funds which were released were used mainly for new infrastructure projects . . insufficient attention was paid to the maintenance of facilities"

Human Resources for Health

- "Hiring of staff had been frozen .

With all of the abovementioned problems experienced in Phase 1 of the implementation of interventions in the NHI pilot districts during 2012/2013-2016/2017 we cannot see how Phase 2, in 2017/2018-2021/2022, and phase 3, in 2022/2023-2025/2026 will be any different or be successful in the current context of the struggling public health care sector.

In light of the abovementioned report, the South African public and taxpayer have no form of guarantee from the government that the NHI will be a success and that health care will not completely collapse in the public and private health care sectors. Based on the findings of this report, it does not seem like the NHI will be a success in South Africa.

12. State-Owned Entities

Chapter 3, Section 11, of the NHI Bill, subsection (l)(d), refers to the investment of money that is not immediately required for the conduct of the NHI Fund's business and states that the Fund may realise, alter or reinvest such investments or otherwise manage such funds or investments. The main concern of the general public is that the NHI will simply follow in the footsteps of Eskom, Transnet, Denel, the SABC, SAA and others. The Minister of Health, however, holds the view that the NHI will not take the same risks as Eskom. This statement is a bit vague and disconcerting and government cannot ensure that the NHI will not suffer great financial losses, like the other state-owned entities, and no clear answer can be provided with regard to how the Minister and government plan to manage the NHI Fund to prevent looting and corruption from occurring in the NHI. The fact that corruption occurred within the South African Police Service's medical aid, Polmed, as an amount of R15,7 million was unlawfully allocated to the Fund's board of trustees over three years, means that the Minister cannot give any assurance that corruption will not take place within the NHI. The only thing that the Minister could say during the Committee meeting held on the 29th of August 2019, was that "corruption will be a major challenge." It is, thus, clear that a corruption-free NHI cannot be guaranteed. And as a result, the NHI will be looted.

13. Infrastructure and the Challenges in Health Care

If the South African government was genuinely concerned about its citizens' medical wellbeing, it would first have ensured that South Africa's existing state hospitals and clinics are turned around and fully upgraded before it came up with a system like the NHI. This Bill will surely provide government with the power to decide what treatment a patient will need, who will provide the treatment and where a patient should get such treatment.

The NHI is clearly not sustainable and should be abolished with immediate effect. At present and on the one hand, South Africa has a public health care sector that has a footprint in even the smallest of settlements, but it is characterised by inadequate supplies and a lack of expertise. On the other hand, the private health care sector maintains world-class standards.

The biggest challenge in our health care is a lack of expertise. Mismanagement and corruption have destroyed the public health care institutions. The government's obsession with transformation means that even more expertise is forced out of the sector - so much so that thousands of our health care practitioners are working abroad.

Cooperation must be established between the public and private health care sectors so that expertise and facilities can be shared. The main objective must not be transformation, but good, accessible health care for all citizens. Sound management practices must be implemented at all hospitals and clinics. Only people with managerial experience must be appointed as chief executive officers at hospitals.

The FF Plus condemns the over-regulation of the medical aid industry whereby the funds are taxed excessively and the nett tax burden on individuals is increased. The medical aid industry and private medical services industry are crucial partners in offering good quality health care services in South Africa.

We should endeavour to establish a national partnership between private and public medical services that will allow enough leeway for both of these sectors to function without any unnecessary restrictions in the interest of a healthier population.

Thus, the process of implementing the NHI must be terminated. First upgrade public health care infrastructure and appoint experts. Stop the over-regulation of the medical aid industry.

Establish a mutually beneficial partnership between private and public medical service providers.

During October 2019, the Office of Health Standards Compliance admitted to the Portfolio Committee on Health that it does not have enough inspectors to inspect the approximately 5083 hospitals and clinics in the country due to a lack of money and other resources. Currently there are a total number of 407 public hospitals, 203 private hospitals, 3863 public clinics and 610 private clinics in South-Africa. It was a shocking revelation that there are only 44 inspectors who have to do all the work across the entire country. As a result, many hospitals and clinics are simply not inspected to ensure that they comply with the legal requirements for delivering safe and high-quality health care to South Africans.

This explains why the infrastructure at hospitals and clinics is in such a poor condition and why equipment is not maintained or in working order. There is simply no money available to fill the vacant positions. During the 2018/19 financial year, only 80 health care institutions were inspected.

If this is such an extensive problem now already, there is no guarantee that it will improve or be solved under the NHI.

In addition, there are not enough emergency vehicles, including ambulances, available in each of the nine provinces.

Eastern Cape	882 vehicles (45 not roadworthy)
Free State	239 vehicles
Gauteng	1143 vehicles (100 not roadworthy)
KwaZulu-Natal	779 vehicles (45 not roadworthy)
Limpopo	591 vehicles (27 not roadworthy)
Mpumalanga	195 vehicles (20 not roadworthy)
North West	119 vehicles
Northern Cape	222 vehicles (86 not roadworthy)
Western Cape	517 vehicles

Thus, out of a total of 4687 emergency vehicles a number of 323 vehicles are not in operation. It may not seem like much, but during a state of disaster even seemingly insignificant statistics can make a big difference.

It is, furthermore, seriously alarming to note that for a population of approximately 58 million people there are only 4364 emergency vehicles available. It is also alarming to note that during the period 1 April 2019 to 18 October 2019, the following provinces procured the following number of emergency vehicles, including ambulances:

Eastern Cape	0
Free State	50 (to be procured)
Gauteng	130
KwaZulu-Natal	88
Limpopo	0
Mpumalanga	35
North West	0
Northern Cape	0
Western Cape	2

14. Parliament's Public Participation Process

During the public participation process conducted by the Portfolio Committee on Health, the following inputs were made by members of the different communities in Port Elizabeth, Queenstown, Mthatha, King William's Town, Rustenburg, Vryburg, Klerksdorp, Soshanguve, Kagiso, Soweto and Germiston. Although all the political parties, unions, civil rights organisations etc. were present at these hearings, the following notes reflect only the concerns of the members of the public.

Nelson Mandela Metro (Port Elizabeth), 29 November 2019:

Why will public health under the NHI be centralised to the office of the Minister? The powers must stay on provincial and local level.

There were concerns from people who stated that they do not have adequate clinics or no clinics at all in their respective communities and they want to know how they will benefit from the NHI.

- A shortage of staff, medicine, health care workers, ambulances and doctors. The question was raised where funding will come from to provide the communities with these critical services. They also wanted to know how these services will be improved. Communities were unsure how the implementation of the NHI will take place.
- Taxpayers are shrinking and will not be able to keep funding the NHI. Money goes to the legal cases of the Department of Health. The question of how government will be held accountable for funds was raised and it was stated that provincial hospitals are far worse than clinics.
- To put private and public health care in one system will crash the system in South Africa. Government must first master health care before exploring the NHI. The problem lies with politicians and government officials who are corrupt and take our money.
- Security and safety at clinics are a big problem.
- Clarity should be given on how funds will be transferred or used between national, provincial and local governments. There is a serious lack of resources in our communities. At 04:30 in the morning, there is already a long que at clinics because people want medical attention, but due to a shortage of staff and medication not all people are attended to. Complaints about the infrastructure of the clinics. No or little support from government.
- More health care workers are needed for clinics to be open 24 hours.
- Shortage of nurses at clinics. No medication and no security. People spent the whole day in queues without getting any medical attention or being attended to.
- South Africa is not ready for the NHI. The conditions under which nurses are working are not good. No services at the clinics and conditions are poor. Facilities are falling apart and there are not enough nurses for all the patients. The clinics are also not safe. First start with the basics before the commencement of the NHI. Doctors and nurses will leave South Africa when NHI comes into effect. Build facilities and get infrastructure in order before the NHI can be launched.

Chris Hani District Municipality (Queenstown). 30 November 2019:

- Clinics are without water and medication.
- People are appointed in the clinics without the posts being advertised. No equipment and the Department of Health does not respond to complaints. Some areas have only one ambulance and took the whole day to respond. Always a shortage of medication.
- The workload in hospitals is too high and additional facilities need to be built and more space is needed. More inspectors are needed.
- The sewerage systems are always blocked at clinics, they are understaffed and no transport available to and from clinics.

- Most of the areas have staff shortages. Hospitals are too small.
- There is a concern about corruption. The question of how it will be ensured that government does not lose the funds of the NHI was raised. Clinics are like a pigsty and an embarrassment. Only South Africans should benefit from NHI and not foreign nationals.
- Shortage of staff at hospitals. People are complaining but nothing is happening.
- No medicine at the clinics.
- Clinics must borrow equipment from clinics in other areas to pass the inspection test. Clinics are under-equipped and struggling to meet the need for proper standards. Shortage of ambulances.
- Clinics were without electricity for three years and were then closed down.
- Shortage of nurses.
- Not enough doctors. People arrive early in the mornings at the clinics and hospitals and wait till late at night without any help.
- South Africa is not ready for the NHI. This Bill will not solve our problems. The NHI Fund will be put at great risk. No competency. Too much corruption. Another tragedy will occur with funds. There is an uncontrolled influx of people entering the country and they will cross the border just to come and take our medication. Registration for NHI will be chaos due to false identification and documentation. Good practitioners will be lost to international countries. Is the process budgeted for and what is the costing of the NHI? We are not ready for the NHI and need to go back to the drawing board.
- Clinics are understaffed and need renovations. People of the community raised funds to install electricity at the clinic. The community requested the municipality to help with connections.
- Government does not assist with the building of the clinic. Infrastructure has to be looked at. Problem with ambulances. Hospital not fully equipped. Lots of backlogs.
- No electricity. Medication is a problem.
- Maternity ward not fully equipped and shortage of staff.
- Ambulance was phoned for a problem but it never showed up. Hospital has only four nurses and no theatre.

OR Tambo District Municipality (Mthatha), 1 December 2019:

- Patients are not treated well at clinics, especially older people. Ambulances are a problem. Standard of hospital was downgraded and staff members were made fewer. No reason for downgrading. Must be upgraded and staff increased. No one on standby at state hospitals and rather went to private hospitals. Don't bother to call an ambulance.
- Pleaded with provincial committee to come and visit the hospital but no one came. NHI cannot be implemented with the current infrastructure we have because it is not suitable. Hospital was already started in 1929 and when compared to 2019, it is not suitable. A submission was already sent in 2013 for infrastructure upgrading, but nothing happened.
- Need building of hospitals because the infrastructure in current hospitals is very poor and nurses are trying to make do with what they have. No doctors. Not enough beds. People need to be transported to East London, but they are lying on the floor waiting for ambulances. Patients are not treated with respect.

- Local doctor in the area for 42 years in the local hospital. One challenge concerning the Bill is the issue of litigations in the Eastern Cape and Gauteng. We are the world's most violent country. Security challenges at health facilities. Shooting took place in one of the clinics. There are challenges with Eskom and SAA. Will NHI follow the same path? Look at the pilot projects. There are too many challenges. It is not clear who will pay the doctors and specialists under the NHI. Will we work for a salary? There are now a lot of doctors who are exploring immigration to other countries.
- Hospitals are not enough and also far away.
- Victim of health system in South Africa. In 2007, I was a trainee in one of the government departments. I was in an accident and taken to Pelonomi Hospital. While ill was taken off the stretcher, the Minister was visiting the hospital and I was placed in the private site of the hospital. When the Minister left, they took me back to the public site. I am scared to go to the hospital. NHI must not be open to everyone in Africa. No asylum seekers!
- The number of clinics is a problem and they are too far. Had a mobile clinic for ten years but it is good for nothing. Only visits our community once in three months. Always making excuses that vehicle is broken. A site was identified for a new clinic, but building has not started due to the budget.
- Qualified nurses don't do what they are supposed to do. The hospital always has a problem with finding your file. The clinic is always full. People standing in long queues. Only four nurses and they are working very, very long hours. People get chased away if they do not visit the correct clinic in the correct area. I had to assist a lady who was giving birth because she was chased away from the clinic.
- Officials of clinics and hospitals should be here today at this meeting. Nurses in clinics do not work and sit and cut their nails while people stand in long queues. And they drink while they are on duty. Patients are not treated well by the nurses. Hospitals do not ask what is wrong with you, they just treat you for whatever. The health system tramples our human rights. No chairs for patients to sit on. Clinics do not have medicine; they send you to the private chemist.
- Too few clinics too far away from each other. Hospitals needed. Infrastructure needs attention. Nelson Mandela Hospital gets overcrowded and security is a problem. Department of Health should reach out to schools to teach children about hygiene. Food inspectors needed in communities.
- Corruption in SA is a concern. Security in hospitals is a problem. Security guards ran away from criminals to go and hide under patients' beds. Need SAPS mobiles at hospitals. Hospitals need upgrading. Only promises. Sick and tired of promises.

Buffalo City District Municipality (King William's Town). 2 December 2019:

- We do not get some medical services at the clinics.
- Clinic workers do their best with what they have. Understaffed and not leaving patients unattended. Some nurses need to be educated. Need more staff members.
- Staff shortage at clinics. No cleaners and full of litter. Government does nothing about this mess.
- Elderly people stand in long queues at 05:00 in the morning due to shortage of staff at clinics. Some of them wait till 16:00 without being attended to.

- Small clinic. Built in olden days. Does not have enough staff members. Clinic needs to be the size of a hospital due to the number of people using the clinic.
- I am a specialist. I want to know about subsidies for research. NHI does not make provision for mental health services. We are leaving the country to Britain, Australia and New Zealand. What is the plan for this brain drain?

Rustenburg Town Hall, 30 January 2020:

- Water and electricity are a problem at the clinics. Ambulances do not work effectively.
- Bring state hospitals up to standard.
- Going to watch the Department of Health closely. Any wrongdoings will be reported.
- CEO of the NHI board must not be elected by the ANC. Hospitals in this area are very bad. Children run the risk of drowning at the clinic because of a water dam that is open at the back of the clinic. Afraid of the NHI. The people who are introducing the NHI are people who are only thinking of themselves. CEO and board members should be appointed not because of their political party but their talent.
- Only one hospital in Rustenburg for all the people in Rustenburg.
- Current infrastructure must be repaired first before NHI can be implemented.
- Financial implications on South Africans. Number of income taxpayers is getting smaller by the day.
- NHI is just another monopoly system like Eskom, SABC, Denel etc.

Vryburg Municipality, 31 January 2020:

- Economy is not doing well. Effective financial management policies are not in place. ANC has failed to lead this country for 25 years due to misconduct and mismanagement. The ANC cannot implement the NHI Bill, they failed to manage this country.
- I have been a pensioner for 11 years. We have a problem with bleached water. How must we use medication with bleached water in the hospitals? Nurses ignore you. There is always a shortage of medicine at the hospital.
- NHI will cause controversy. People cannot wait for the NHI to decide when and where you can go and visit a doctor. NHI cannot be implemented due to a bad economy. NHI will follow in the footsteps of Eskom and SAA. There will also be a problem with medical aids. Nurses shout at people at the clinics. Old people are not treated like humans. Hospitals do not provide enough health services.
- Problem with the Health Department. Because of poor services provided by the hospital, my brother is dead. No monitoring and evaluation and no medicine.
- No medicines in hospitals and clinics. Patients must buy medicine at other places. Shortage of staff. We are working under very bad conditions. Accreditation of the clinics: when inspectors came to the clinic, the personnel put out a few medicines and equipment that they borrowed from other clinics and hospitals so that they could pass the inspection.
- How will the NHI assist us as nurses? We have a challenge with shortage of staff. One nurse works alone with 169 patients per day. Please help us get more nurses. We have a shortage of medicine and the patients blame us for that problem and do not treat us well.

- Clinics work only eight hours a day. Many villages with not enough clinics. More clinics must be built. We also have a shortage of doctors.

Klerksdorp, 1 February 2020:

- The question of whether anybody will have to pay anything towards the NHI was raised. Shortage of staff in hospital and clinics, shortage of resources at public hospitals and many people dies in these hospitals.
- We need confidence in the NHI to assist us. We are not trusting our government. The clinics and hospitals are very bad and it smells and it is very dirty. Ambulances arrive at a scene five hours too late. Patients do not get the services they deserve.
- Support NHI, but with some concerns. With regard to the health sector anti-corruption forum, which was initiated in October 2019 by the President, the people have the following concerns: It is a beautiful idea but corruption will destroy the system. There is no confidence in the public health care sector.
- We are not happy with the state of affairs at the clinics due to a shortage of staff; people are employed in the Department because they are connected. Clinics are filled to capacity and very small. Patients are not treated well.
- How will people who do not have ID documents be registered on the NHI?
- We need clinics. Large numbers of patients are dying and there is no help from the MEC.

Soshanguve (Pretoria). 21 February 2020:

- A member of the public complained to the Committee that the person's medical records keep disappearing from clinics and hospitals in Mamelodi. According to the individual, the government has no clue what is going on and how to develop the electronic system for the current situation and the NHI.
- Pilot project of the NHI has failed. People do not have access to quality health care. There is no quality health care. The question of how the NHI is going to be implemented was raised. There was also a complaint about the failures and shortage of staff at state hospitals.
- Further complaints were also raised about the current infrastructure of hospitals and clinics. It was stated that facilities and toilets need to be fixed.
- The chairperson of the hospital board raised a concern regarding the funding of the NHI and the relationship between the private and public health care sectors.

Kagiso West Rand District Municipality, 22 February 2020:

- Deeply concerned that the NHI is not necessarily the answer to our health problems. A national health service is needed that is well-managed. Fix our hospitals and we need an increase of nurses and doctors. We need a health service not a health insurance.
- We need more hospitals in our townships and we need more facilities.
- Tell us about the advantages of the NHI and not the disadvantages of the past and the current health system. We have long queues at our clinics and more clinics are needed and this government must make sure that they are functioning.

- There are not enough ambulances and currently they are shared. Infrastructure is a problem. There are not enough beds and a shortage of staff.
- Impressed by the NHI, but how much will people have to pay at clinics and hospitals under the NHI? There is a severe shortage of staff as well as clinics and hospitals. Some sections of the clinic have been closed down and the quality of service is poor.
- The clinics are not open 24 hours and there is a problem and a shortage of ambulances. The clinics have a shortage of nurses.
- Go back to the basics of how health is implemented. Patients' files are always missing and there are always long queues and we need efficient staff members. The Batho Phele principles do not exist and there is no respect. Private hospitals provide good service compared to public hospitals.
- At the Baragwanath Hospital, my family members are waiting to die.
- Where will the funding of the NHI come from and why are doctors leaving the country? We have a huge shortage of doctors, we received poor service and the NHI will be managed just like a state-owned entity.
- State hospitals are poor and there is a shortage of staff. Concerned about the challenges and the NHI will be forced on to the people.

Soweto (Johannesburg), 23 February 2020:

- We need to know what the NHI is. Parliament needs to invite people to meetings and there are no meetings taking place for the clinic committees.
- Reject the NHI. Public Health as we know it must first be fixed with enough medication and adequate staff. You are chasing away health professionals.
- Pilot sites of the NHI not monitored. How will NHI fix the broken hospitals? Shortage of medicine and equipment.
- Issue of staff and nurses at clinics.
- Issue of affordability and pricing. Issue of hospitals and doctors. Need qualified experienced doctors.
- Shortage of nurses of over 30 000. Who will benefit from the NHI? Human resources need to be addressed.
- We are neglected as a community of health workers. Will we have a role to play under the NHI?
- Rural areas need attention. Worried about long queues and that foreigners will flock to South Africa. Communities should be part of decisions regarding the NHI.
- Shortage of nurses and sisters and we are working under great pressure.
- The NHI is a resolution of the ANC. The current health system is a legacy of the Apartheid government. Medical Aids and private schemes cannot be allowed to be part of the NHI. The NHI Fund will be funded with too much money.

- It is one thing to write a Bill, it is another thing to implement it.
- Clinics run out of medication and people do not get assistance at the clinics. They will not attend to you because you are from another area.
- In terms of infrastructure, there are a lot of concerns. Infrastructure at Charlotte Maxeke is a mess. Our issues must be taken seriously. Our health facilities were far better during the Apartheid era. There is a shortage of doctors.
- Segregation. When visiting the Baragwanath Hospital, people are told that they cannot visit the hospital because they live in another area.
- Foreign nationals stole our medication in our clinics and took it back to their countries.
- We have one of the worst hospitals ever in Soweto. The clinics' toilets are a mess with no toilet paper. People arrive at the clinics as early as 04:00 in the morning. Elderly people stand in long queues. There is a challenge with pregnant women in our clinics and hospitals. Women are sent back home because there are no beds available.
- NHI will be riddled with more corruption. The minister must not overcompensate himself with powers he does not have. Infrastructure must first be fixed.
- NHI is not what it's promised to be. Resources are needed in the hospitals and clinics. What is the board of the NHI going to cost us? All our hospitals do not have adequate resources. The Department should engage with all the sectors. Discussions need to be held.
- The taxpayer already pays too much. NHI will be open to corruption. South Africa has a human resources crisis and medical doctors already indicate that they will immigrate to other countries. The NHI will collapse the health system.
- The NHI will be managed like a state-owned entity and will be open to corruption. The NHI will be looted like the SAA and Eskom.

Germiston City Hall, 24 February 2020:

- It is vague and unfair to ask members of the community to give input on a Bill which is not clear to us. Jakob Zuma received medical treatment in Cuba so how can this Bill be trusted?
- The NHI will not work.
- There is a gap between the rich and the poor that needs to be closed.
- Everyone, whether poor or rich, should get the same standard of medical care. We cannot afford medical aids.
- Medicine must be brailled for blind people.
- No hospital in Katlehong and very few clinics available for all the residents of Katlehong. The attitude of staff in the clinics needs attention.
- Problems with infrastructure and not enough medicines. Enough money must be allocated to hospitals.
- Patient services need to be prioritised. The Compensation Fund is a problem; but NHI Fund in one pool is a problem. The worst hospitals get contracted. Currently, private hospitals supply all services. Uncertainty with regard to staff employment.
- I took my father to Katlehong Hospital. We could not be assisted there. I request a hospital that can provide speedy health care.
- What kind of jobs will be created by the NHI? Will the correct educated people be put in charge of the NHI? We need systems in hospitals, not in Parliament.

- What will happen if the Fund is looted? Service levels are not optimal at current facilities. I waited six years for my prosthetic leg. The attitude of the staff at hospitals and clinics is a problem. Government officials must lose their medical aids so that they can visit a state hospital and feel what we are feeling.
- Who will fund the NHI?
- Medical staff have a lot of challenges.
- Worried about state-owned entities. Assist township areas because they are failing us, and we do not have doctors.
- Need to find a system that will make our health care system sustainable. Corruption is a problem. Inequality is not the question here and what evidence do we have that NHI is practical and sustainable?

15. State Hospitals and Clinics

The government must indicate how it plans to turn around the Department of Health and how it will save the Department from sinking ever deeper into the pit of corruption and poor service delivery. Government needs to indicate how it plans to improve the terrible conditions in state hospitals and clinics as well. In addition, government must also explain what it is going to do to ensure that medical staff members who do not care for patients as they ought to or who even assault patients in hospitals and clinics are held accountable. Thorough high-level investigations must be conducted into the numerous deaths in state hospitals and the strange circumstances under which these deaths occurred. South Africa's state hospitals and clinics are in a terrible condition and service delivery is extremely poor. That places immense pressure on nursing staff and doctors who have to get by with inadequate equipment and medicine. A question for written reply was sent to the Minister of Health on the 18th of October 2019, question no. 1190, internal question paper no. 20, to enquire about the problems experienced with the maintenance of medical equipment and machinery in state hospitals: (a) what type of equipment and machinery is out of order in each hospital in each province and (b) for how long have such equipment and machinery been out of order in each case and what are the reasons for delays in affecting repairs and maintenance timeously? The response to these questions was very alarming. The Minister replied as follows: "The types of equipment that are reported to have problems in public hospitals vary from small to large equipment. Maintenance of medical equipment (both corrective and preventive) is conducted by, or under the supervision of, Clinical Engineering Units at hospitals and districts. While some specialized items and systems are outsourced, some medical equipment is maintained and serviced in-house by our Clinical Engineering Technicians with the aim of ensuring that all items critical to health care service delivery are returned to full functionality as soon as possible. Equipment servicing (planned maintenance), such as that performed on life-support equipment, is conducted in accordance with agreed schedules that are handled at hospital level and does not result in a lot of downtime prior to servicing, and mostly momentary downtime at the time of servicing." "Different provinces indicate various types of equipment that are out of order for a moment, but most are in the process of being repaired / serviced or replaced." "For corrective maintenance, depending on the nature of the fault, equipment downtime is variable and dependent on the need and can range from an hour to weeks and even months if specialised spares need to be shipped in from manufacturers or suppliers overseas. Delays also occur as a result of (i) supply chain prescripts and processes associated with procurement of spare parts and / or services, (ii) in-house technical staff

shortages and (iii) slow turnaround by service providers for equipment maintenance that is outsourced. "In addition to the reasons stated some of the additional reasons include: (i) centralised budgets for maintenance and (ii) limited budget (lack of funds)." The current problems in our state hospitals and clinics and the Department of Health must urgently be addressed and rectified in the interest of all South African citizens.

South Africa's health care system is in a deep pit — not due to a lack of funds, but due to mismanagement, corruption and incompetence. Government is now expecting the very same officials who are responsible for the current chaos to manage its grandiose NHI. It is obviously doomed to fail. In July 2019, only 16% of South Africans had access to health care services even though state health care services can be found even in the farthest corners of the country. Therefore, it is clear that the problem lies with service delivery and not accessibility; with the people who are managing the service. Government is failing miserably in this regard. One of the main causes of this failure is the government's obsession with transformation. The ANC is transforming everything in the country into a mess. Seeing as the current system is not being managed properly, any dream of implementing another system is bound to turn into a nightmare. The NHI plan and Bill must be abolished at once. It is a recipe for disaster and it will not improve hospitals and clinics.

16. Shortage of Doctors and Nurses

The current shortage of nursing staff makes the implementation of the NHI impossible. According to the trade union Solidarity, 8535 fewer nurses entered the labour market since 2013 and the number of qualified nursing staff members has decreased with 40% since 2013 July 2019).

This is due to an excessive workload, long hours, working under difficult circumstances, a lack of support and equipment and a lack of funds. The circumstances in our country's hospitals and clinics are absolutely shocking. Security is so bad that nurses, doctors, students and patients are assaulted and even raped. On top of that, many patients die under strange circumstances. Even if someone is only admitted to the hospital with a broken leg, the person cannot be sure that he / she will survive. A non-governmental organisation, Health Systems Trust, issued a report on the 27th of January 2020 indicating that compensation as a result of medical negligence amounts to a staggering R104,5 billion for all nine provinces. The head of this organisation, Dr Themba Moeti, said in a statement that this report provides a perspective on the great challenges faced with the implementation of the NHI. During the 2021/22 Financial year it was reported to the portfolio committee on health by the Auditor General during a meeting in October 2022 that medico legal claims against the Department of health has amounted to 15 148 claims with a value of R125 Billion. During September 2022 the minister of health reported in a written answer to the FF Plus that the backlog of medical procedures in South-Africa's state hospitals amount to a staggering 175 084.

In a question for written reply that was sent to the Minister of Health on the 20th of September 2019, question no. 979, internal question paper no. 17, the Minister was asked what he found to be the reasons for why the Republic has a shortage of doctors and nurses in state hospitals? The Minister's answer stated: "The primary reasons why the Republic has a shortage of doctors and nurses is the fact that the Public Health Sector budget has not been increasing in real terms for the past ten years, impacting on the number of staff that can be appointed. Furthermore. the demand for health services

in the country is increasing while there is no additional funding to address the change, which results primarily from immigration into the country and the increasing burden of disease." During February 2022 the minister of health reported in a written answer to the FF Plus that there were a total number of 1339 vacant post for doctors in state hospitals and a total number of 10831 vacant post for nurses in state hospitals.

South Africa's health care services are in a terrible state and the government is making a big mistake if it thinks that the NHI is a magic wand that will solve all the problems. It is also disturbing to learn that the Department of Health underspent its budget with R1 billion in the 2018/19 financial year. According to the Auditor-General, hospitals in Mpumalanga, Gauteng, KwaZulu-Natal and the Free State have still not started using medical equipment that was purchased in 2015 for an amount of R13,2 million. All these facts paint a picture of sheer incompetence. The Auditor General also reported to the portfolio committee on health on 19 October 2022 that an amount of R1.3 billion worth of fruitless and wasteful expenditure had been incurred by the Department of Health. The department could only receive a qualified audit for the 2021/22 financial year.

South Africa can no longer allow our state hospitals to be run like abattoirs and mortuaries. The government must step in and take decisive action to save our health care system. In the interim, we should forget about the NHI. It simply will not work. During a debate in Parliament on 10 November 2022 the FF Plus asks President Ramaphosa to establish a commission of inquiry into the public healthcare system. This request was done in terms of Section 84(2)(f) of the Constitution. The investigation must, among other things, focus the spotlight on the inhumane treatment of patients in state and provincial hospitals. The reality is that government has allowed, and to the large extent played an instrumental role in, turning state hospitals into abattoirs and mortuaries. Large-scale corruption, mismanagement, maladministration and incompetence, which have brought the healthcare system to utter ruin, are a serious cause for concern for all South Africans. It is also easy to see why the public has no faith in this incompetent government to implement a National Health Insurance system.

In June 2022 the FF Plus has requested the Human Rights Commission to investigate the inhumane treatment of patients that took place in state hospitals. The FF Plus also requested the public to come forward with their stories on the matter and till date the FF Plus has received a lot of complaints about the following hospitals:

Gauteng:

- Pretoria West hospital
- Steve Biko hospital
- Far East Rand hospital
- Kalafong hospital
- Leratong hospital
- OR Tambo memorial hospital
- Carletonville hospital
- George Mukhari hospital
- Heidelberg hospital

- Kopanong hospital
- Baragwanath hospital
- Germiston hospital
- Ga-Rankuwa hospital
- Charlotte Maxeke hospital
- Tshwane academic hospital
- Helen Joseph hospital

Limpopo:

- Polokwane hospital
- FH Odendaal hospital
- Voortrekker hospital
- Warmbad hospital
- Thabazimbe hospital
- Tzaneen hospital

North West:

- Witrand hospital
- Bojanala district hospital
- Brits hospital
- Potchefstroom hospital
- Tshepong hospital
- Koster hospital
- Vryburg hospital
- Klerksdorp hospital

Eastern Cape:

- Uitenhage hospital
- Frere hospital
- Livingstone hospital
- Dora Nginza hospital
- Andries Vosloo hospital
- Port Elizabeth provincial hospital

Western Cape:

- Malmesbury hospital
- Somerset hospital
- Hermanus provincial hospital
- Paarl hospital
- Karl Bremer hospital

Free state:

- Bothaville provincial hospital
- Bongani regional hospital
- Sasolburg hospital
- Pelenomi hospital
- National hospital
- Universitas hospital
- Kroonstad hospital
- Embekweni / Zastron hospital
- Diamond / Jagersfontein hospital
- Boitumelo regional hospital Parys district hospital
- Fezi Ngubentombi hospital

Mpumalanga:

- Middelburg hospital
- Evander hospital
- Waterval Boven hospital
- Witbank hospital
- Rob Ferreira hospital
- Sabie hospital
- Themba hospital
- Delmas / Bernice Samuel hospital Ermelo hospital

Northern Cape:

- Noupoot hospital
- Connie Vorster memorial hospital
- Kakamas hospital
- Kimberley / Robert Sobukwe hospital Loeriesfontein hospital

Kwazulu-Natal:

- Greys hospital
- St. Mary's hospital
- King George / King Dinuzulu hospital

The government's plan to "steamroller" the NHI Bill through Parliament and to have it passed as legislation will cost South Africa dearly. Adopting and implementing the NHI will cause experienced medical professionals to leave the country. Government is still unable to provide clarity regarding how the NHI will be financed and what role medical aid funds will play under the NHI. Everything seems to indicate that the government is aiming to get rid of medical aid funds with the NHI and that will surely deliver another significant blow to South Africa's already struggling economy.

The small pool of taxpayers in this country will become overburdened with the NHI and will not be able to afford paying the compulsory contributions to the NHI, medical aid contributions as well as the

already high taxes. The government's plan to use the NHI to upgrade the dilapidated infrastructure at state hospitals will also not work and the NHI will only be implemented as a means to obtain more funds from taxpayers and commit even more corruption. Shortcomings in the proposed Bill are setting alarm bells ringing seeing as the proposed Bill does not even specify which services will be covered by the NHI.

The fact that patients will not be able to see a specialist or doctor because the NHI will not pay for it before the patient is registered at an NHI-accredited primary health care facility and the facility refers the patient to a specialist is extremely disconcerting. If government is presently failing to provide proper health care to patients at state hospitals and clinics, it raises the question of what will happen in the future under the NHI? Registered immigrants from other countries will have access to all medical services under the NHI, which will be financed by South Africa's hard-working taxpayers. We cannot see how the NHI will save the country's health care services. Instead, it will only bring about the downfall of South Africa's health care services.

17. Covid.19

With the outbreak of the Covid-19 virus in South-Africa, it was already clear in the early stages of the pandemic that South Africa's public health care system was not geared to handle this pandemic. Before the peak of the virus, which was predicted to be reached in the months of August and September 2020, it was already evident at the time that the pandemic cannot be curbed and controlled by the public health care system alone as it was relying heavily on assistance from the private health care system. In turn, the private health care system indicated at the outset to government that it will assist in combatting the spread of the virus and treating patients who are infected. And they did. From a media release issued by the Minister of Health on the 20th of April 2020, it could be gleaned that the public health care system's laboratories were inadequate to perform the large number of Covid-19 tests. In this media release, the Minister of Health reported that the public health care sector could only perform a total number of 40 698 (33%) tests, while the private sector had conducted over 80 812 (67%) of the total of 121 510 Covid-19 tests. These were early signs that the public health care system is buckling under the pressure of the burden of Covid-19. As a result, the burden on the private health care sector to combat the spread and treat the virus could soon become overwhelming seeing as the public health care sector is not up to standard to provide the necessary care to patients.

While South Africa was under lockdown during the month of April 2020, it became evident that the situation in which South Africa finds itself as regards the shortage of medical equipment was approaching a critical point. In early April 2020, the Portfolio Committee on Health requested the Minister of Health, Zweli Mkhize, to urgently investigate these shortages.

At that stage, South Africa had a mere 6000 ventilators available and just 2000 of those were in the public health care sector. Concerning the shortage of intensive care beds, at that stage, there was a total of only 7195 beds available in both the public and private health care sectors.

The shortage of ventilators could be ascribed to the fact that it is a worldwide problem, particularly because health care systems usually operate based on the typical need plus only a small degree of additional capacity.

The shortage of masks and other protective clothing for doctors and health care workers in hospitals and clinics must be a top priority for the Department of Health even in a time where there is no threat. If doctors and other health care workers are not provided with the protection they need, South Africa will face an enormous crisis that will put additional pressure on the struggling health care system. Doctors with private practices who helped out at clinics in the Hekpoort area in Gauteng complained that they are putting their lives at risk as government cannot provide them with personal protective equipment (PPE). The FF Plus directed more than four private companies to government to help with the supply of surgical masks and gloves. It was during the time that the Gauteng Department of Health requested help from the public in the form of donations for PPE and other medical equipment.

Over the years, the public health care sector has underinvested in the manufacturing and procurement of critical medical equipment. The demand for ventilators is already exceeding the supply and, thus, methods to give preference to the patients who need it the most will have to be considered at some stage. The criteria for admission to intensive care units will have to be very transparent and must be determined in cooperation with the Critical Care Society of Southern Africa. In order to do this, a panel consisting of leading experts must be established.

South Africa's population is currently about 58 million people and according to all indications, more than 60% of the population will be infected with the coronavirus at one stage or another - an estimate of approximately 36 million people. An estimated 4% of these people will need ventilators, that adds up to approximately 1,44 million people. Evenly distributed over a period of a year, it comes down to approximately 12000 people per month. It is, thus, abundantly clear that the crisis South Africa are headed toward is becoming increasingly serious.

The conditions at the quarantine facilities, which were earmarked for the Covid-19 lockdown period in accordance with the announced state of disaster, were terrible. During the month of April 2020, it came to light that the details of most of these facilities were still unknown to the public and even to the members of Parliament. The problems experienced at some of these facilities that were reported by members of the public indicated that the facilities had not been prepared properly so they were not ready to use and to fully serve their purpose. The FF Plus received complaints about the facilities in the areas of Limpopo and the Northern Cape. Complaints ranged from no water and food being available to places that are filthy and food that is inedible. Two of these facilities were state hospitals, namely the Harry Surtie Hospital in Upington and the MDR TB unit in Modimolle. At that stage, the Department of Health and the Department of Public Works and Infrastructure had neglected their duty to oversee the preparation of the facilities that had been earmarked as quarantine centres and also did not perform the necessary inspections to ensure that the facilities meet the requirements.

Details regarding the quarantine facilities should have been provided so that members of Parliament, provincial legislatures and municipal councillors could have effectively performed their oversight role in this regard while taking the necessary safety precautions. Too many complaints were received from persons who had to stay in these facilities after entering South Africa from neighbouring countries and even from overseas and it became clear that the facilities were not fully equipped to accommodate these people. The regulations under the lockdown stipulate that people who travel across the border posts to South Africa must stay in these quarantine facilities for a period of 14 days. However, the

facilities lack proper water supply, electricity, food, beds and even clean linen and the facilities are also not cleaned and sanitized on a regular basis. Numerous complaints were received about the facilities in Ellisras, Upington, Nababeep and Tembisa. It is, thus, imperative for the Department of Health and Public Works to perform the necessary inspections to ensure that everything is satisfactory and in place at these facilities - but that clearly did not happen. Staff at these facilities were also not properly trained. Communication problems occurred between the national and provincial departments as well as municipalities regarding the setting up and the management of these facilities.

State hospitals are also in a terrible state with a lack of personnel, doctors, nurses, medical equipment, food, water and proper beds. Patients kept in isolation at Durban's Clairwood Hospital were, according to media reports, being served with stale food containing maggots. As reported by Sne Masuku from the media platform IOL on the 16th of April 2020, patients, some of whom were in isolation for more than 14 days, took to social media to complain about the food they were being served. According to them, the food was brought later than expected and while eating, they spotted maggots in the food. They have not been served fresh food since their arrival at this hospital. They were worried about the detrimental effect this would have on their health as they were diagnosed with the coronavirus.

Complaints were also received from patients at the Limpopo MDR TB unit in Modimolle that stipulate this state hospital's unpreparedness to combat the virus. On admission, the patient room was very dirty and the room was not cleaned or sanitized before the arrival of the patient. There was no soap available in the room for the patient to clean his / her body.

Nurses working at the Beethoven Psychiatric Hospital in the North West reported that even though there was a positive Covid-19 patient in their facility, they received instructions from management stating that operations must go on as normal and that they had to work without any protective clothing, masks, gloves and that no PPE was provided to them. It was also a clear indication that this state facility was not adequately prepared and did not have the necessary equipment for patients or staff members in order to handle this matter correctly.

On the 17th of April 2020, a patient in the Tshepong Hospital in the North West, who was being kept in the Covid-19 isolation ward while awaiting test results, reported that poor safety protocol was followed, conditions were unhygienic, there was a lack of proper water supply and toilet facilities and the food was also substandard. There are numerous other critical issues that also require attention before the outbreak worsens and the pressure on facilities increase as they admit more and more patients. These matters include improved cross-infection containment measures in the ward, including but not limited to, PPE and the general movement of people in and around the ward, clean linen, drinking water and the provision of meals.

The cups in which patients were served coffee out at the hospital were not always clean. There were only two working bathrooms in the entire hospital ward. Patients could not drink water from the taps as it came out dark brown. The shower's geysers were also not working. The nurses who worked the night shift had to take patients to another ward so that they could take showers regardless of whether this put the patients at risk of getting sick due to the cold weather. The bathrooms and showers were also not clean. The cleaners were arguing loudly in the ward and, as at some of the other quarantine facilities, refused to clean or did not clean properly. Hospital staff were also moving around without gloves and masks. The bedding on which patients had to sleep was dirty and torn. Patients had to sleep on bedding that came out of the laundry basket and that was not washed. The staff and management of this hospital did not treat the patients in a respectful manner. The food was not edible.

The toilets were dirty with no sanitizers and men and women had to use the same toilets as the other toilets were out of order. None of the doctors or medical staff were making use of PPE because they did not have any of these items at their disposal.

It is abundantly clear that even before the outbreak of Covid-19, the South African public health care system was not fully prepared and equipped to combat the spread of the virus or even to treat regular patients in state hospitals and other facilities.

18. Corruption in Covid-19 period

Corruption is described as the abuse of entrusted power for personal or private gain. The dictionary defines corruption as dishonest or fraudulent conduct by those in power, typically involving bribery.

When the Corruption Watch Report of 2020 was released, it indicated that they had received no less than 700 whistle-blower accounts from 2012 to 2019. This Report highlighted that the most vulnerable - the elderly, women and children - are the ones bearing the brunt of (a) the shortage of medication, (b) the malfunctioning of equipment and (c) the pressure to exchange undisclosed amounts of cash for goods and services.

There are 4270 public facilities in South Africa. According to the Corruption Watch Report, 28000 whistle-blowers have lodged complaints and 3% of all complaints pertain to health matters. In 2012, the figure correlated to corruption cases was 14,7%. It reached a peak in 2017 at 17,7% and decreased again in 2018 to 15,9%. The fact of the matter is that corruption is having a devastating impact on the health system in South Africa.

On national level, a staggering 670 corruption cases in the health sector were reported. There was a huge percentage of allegations of corruption against provincial governments (52%) as well as national government (40%). The province of Gauteng was in the lead with 39%, Kwazulu-Natal at 16%, Eastern Cape and Mpumalanga at 8%, North West at 7%, Limpopo at 6%, Free State and Western Cape at 5% and the Northern Cape at 2%. Corruption in the South African health sector is categorized as: (1) the embezzlement of funds (transferred from national to regional); (2) the

procurement of medical supplies (fraudulent and counterfeit equipment and drugs) and (3) nepotism (hiring and promotion of staff).

Key role players in corruption include high-ranking public officials (managerial posts), administrators and medical professionals (doctors and nurses) as well as companies bidding for business with the state, but which are already providing the relevant services or products to the state.

According to the Report, employment corruption is at 39% (time claimed for work that is not done), procurement corruption at 22%, the misappropriation of resources at 16%, the abuse of power at 7%, bribery at 5% and fraud at 5%. It was also reported that the appointment of unqualified persons to fill positions contributes to situations where the work is too demanding for the individual who then often neglects their work by not completing tasks and that ultimately results in poor service delivery. A very alarming finding conveyed in the Report is that kickbacks in contracts that often amount to millions of Rands are as high as 10%. Another serious cause for concern is that officials and employees of state hospitals and clinics are mismanaging funds or using the state's resources to benefit themselves and their relatives. This results in a shortage of medicine and medical equipment, which may either be lost or damaged.

The admission by the Minister of Health, Zweli Mkhize, during a media conference on the 26th of May 2021, which was held to address an irregular contract with the communications company Digital Vibes, raises various questions about whether the NHI will be safeguarded against corruption or not.

The FF Plus has repeatedly asked the Minister to assure the people that the NHI will not be affected by corruption, but he was unable to provide such a guarantee.

The Digital Vibes case demonstrates that the NHI will not be immune to corruption and that it is inevitable that the NHI will be hijacked by corrupt politicians and cadres even before it has been properly implemented.

The unlawful appointment of Digital Vibes and the irregular payments amounting to R150 million made to the company between January 2020 and February 2021 serve as proof that corruption stretches far wider and deeper in the Department of Health than what was originally thought.

It is time for the Minister of Health, Zweli Mkhize, to respond with honesty to the questions about Digital Vibes and the seemingly irregular appointments made in his Office and Department.

In May 2020, the FF Plus asked the Minister in writing whether his department had awarded any Covid-19 tenders and if so, what the names of the companies in question are and whether the normal procurement procedures had been deviated from.

The Minister's response indicated that no tenders were either issued or awarded and that goods and services were solely procured and provided by deviating from the normal procurement procedures.

During this time, the name of the company Digital Vibes came up and, in this regard, the Minister said that the company was paid R35 million and R2 million, respectively, to work on a Covid-19 communication strategy and to handle media interviews.

The names of seven other companies also came up and the total amount paid to them added up to approximately R83 million. One of these beneficiaries was the Protea Hotel Resort in Limpopo where the first people repatriated from Wuhan were accommodated for an amount of R11 million.

The FF Plus enquired some more and asked Mkhize whether his department was not setting a bad example by procuring goods and services for such a large amount of money, particularly because the normal procurement procedures were not followed, which immediately casts suspicion on it.

Mkhize's answer was that the emergency measures in terms of the Disaster Management Act were used to deviate from the normal procurement procedures in the abovementioned case. This was despite the fact that thousands of other repatriated individuals had no choice but to stay in terrible conditions at various quarantine facilities across the country.

The FF Plus is of the opinion that Section 27(2)(L) of the Disaster Management Act was grossly exploited to benefit those who have close ties with the Minister.

The Minister's actions just before and after the outbreak of Covid-19 raised many such questions and the numerous media reports on further possible irregularities, like the vehicles reportedly procured for his son, only strengthen the suspicions of malpractices.

With regard to irregularities relating to appointments, the FF Plus had asked the Minister in writing in February 2020 to provide clarity on the appointment of his cousin, Ms Sibusisiwe Ngubane Zulu, as his chief of staff.

At the time, the FF Plus wanted to know whether the correct procedures had been followed in making the appointment seeing as there had been rumours that Ms Zulu may be able to influence the implementation of the NHI.

In his written reply to the FF Plus, Mkhize indicated that the appointment was made in terms of Regulation 66(2) of the Public Service Regulations and that the Minister was, therefore, not required to follow the normal appointment procedures.

The FF Plus implored Minister Mkhize to step up and to be honest with the people of South Africa by providing clarity on all these matters before the Special Investigating Unit (SIU) issues its report at the end of June 2021 as the report could have serious repercussions for Mkhize and the Department of Health.

The Corruption Watch report also states that figures for provinces that are misappropriating funds are as follows: the Eastern Cape 26%, Gauteng 21%, Northern Cape 18%, KwaZuluNatal 17%, North West 16%, Western Cape 14%, Mpumalanga 10%, Limpopo 8% and the Free State with 8%. This is a pervasive problem in the Department of Health. The result is that 13% of health budgets is lost to corruption and it is preventing people from getting adequate health services.

The exploitation of the Disaster Management Act Section 27 (2) (L) during the Covid-19 lockdown resulted in poor quarantine facilities. In addition, the Department of Public Works and the Department of Health's irresponsible procurements, which deviated from the normal procurement procedures, were the result of their hunger for political power. There are many examples to illustrate this: the Zithabiseni case, the debacle around the Coastlands Hotel in Durban, the former MEC of Health in Gauteng, Dr Masuku, who was embroiled in a PPE scandal amounting to R125 million and the digging of massive graves for Covid-related deaths instead of procuring hospital beds, ventilators and other medical equipment, the unlawful procurement of motorbike ambulances by the Eastern Cape Department of Health for an amount of R10 million and lastly, the substantial litigations against the Department of Health amounting to a staggering R111 billion.

In May 2021, the Auditor-General reported to the Portfolio Committee on Health that there was extensive corruption committed with PPE. While there was a serious shortage of PPE at the peak of the pandemic in 2020, hospitals in eight of the nine provinces had left their PPE stock outside in the wind and rain under a sail due to a supposed lack of storage facilities. It is an absolute shame that 600 health care workers had to die because of a shortage of PPE. The Auditor-General described it as "ineffective stock management processes, inadequate storage facilities and poor storage practices".

Regarding the recording, storage and or distribution of PPE, the Auditor-General reported that systems and / or controls to account for PPE were not in place or were not effectively used at bulk storage and health care facilities. The PPE was not distributed in an adequate and / or timely manner to health care facilities. Poor storage practices at all storage and health care facilities were reported as well as limited security controls at these bulk storage facilities.

The Auditor-General also reported that PPE items were not ordered at prices regarded by the National Treasury as market related. Seven out of nine provinces ordered PPE from suppliers at prices in excess of the maximum prices as prescribed by the National Treasury. The provinces of KwaZulu-Natal and Gauteng accepted PPE of inferior quality, which also differed from those ordered and paid for. According to the Auditor-General, goods that were not the same as the ones specified in the original order documents were received and paid for by the Department. The same price was paid for units, which were delivered and accepted, that were smaller than the ones ordered.

The Eastern Cape, Gauteng, Northern Cape and North West provinces' reasons for deviating from the normal supply chain management prescripts were not recorded and / or approved as per the approved delegation of authority, as required by Treasury Regulation 16(A) (6)(4).

Gauteng, KwaZulu-Natal, the North West and the Western Cape procured goods at prices higher than those prescribed by the National Treasury's instruction notes. KwaZulu-Natal, Mpumalanga and the Northern Cape did not comply with local content requirements. The Eastern Cape, Gauteng and KwaZulu-Natal's specifications were also not included on quotations and submissions.

According to media reports in August 2020, 41,5 million PPE units amounting to R673 million were ordered, but only 36,6 million units were delivered; 26,9 million of which was delivered to state hospitals and clinics.

R20 billion was paid to municipalities and provincial governments in preparation for the Covid19 pandemic. This amount included R466 million earmarked for the procurement of PPE by provincial departments. A further R150 million was paid to municipalities on the 8th of May 2020 but only Gauteng, KwaZulu-Natal, the North West and Western Cape reported on the spending thereof. This money was earmarked for sanitizing public facilities, temporary sanitation as well as waste and garbage disposal. A total of R815 million was earmarked for PPE and medical equipment: R670 million for urgent medical stock and PPE for state hospitals and clinics and an amount of R145 million for PPE for community health care workers. Around two million N95-masks, which did not comply with SABS standards, were bought for an amount of R94 million.

On the 24th of July 2020, the health response had spent the following on PPE:

- R68,6 million on community health care workers;
- R551,9 million on urgent PPE for hospitals;
- R179,8 million on test devices for national health laboratory services;
- R28,2 million on testing in academic laboratories;
- R5,3 million on the national ventilator projects;
- R22,3 million on 20000 ventilators that should have been ready for delivery by the end of August 2020;
- The Solidarity Fund ordered 41,5 million units of PPE, but only 26 million was delivered to provinces;
- The Solidarity Fund approved R405 million to supply public hospitals with medical equipment. Particularly beds, ventilators and oxygen equipment for Gauteng, the Western and Eastern Cape;
- For Gauteng: R209 million for intensive care equipment and the NASREC field hospital facility;
- For the Western Cape: R120 million for beds and ventilators;
- For the Eastern Cape: R76 million for beds.

Regarding the matter of field hospitals, the Auditor-General reported that "certain provinces that had made plans to upgrade existing facilities from start did not follow competitive procurement processes. Contracts were not always concluded and approved as required."

It was reported in two special reports published by the Auditor-General in February 2021 that the Department of Public Works in KwaZulu-Natal had spent R34500 per month on 228 beds in a temporary field hospital in the Durban area. The rent that the Department had to pay over a period of six months amounted to R47,2 million. The Department of Health in KwaZulu-Natal gave the orders for this hospital to be opened. According to reports, the Auditor-General could not find evidence of the supposed approval or an outline of the cost of the project and the Department of Public Works could not even provide the building plans to support the expenditure of R47,2 million.

Moreover, the construction of this field hospital took longer than originally planned. It should have been erected within three weeks, but Public Works took six weeks to approve the renovation of the aircon system. In the end, the project took ten weeks to complete. Besides that, there were water leaks, no hot water, no lumbar bed trolleys and a non-functioning intercom system for nurses. The roof had to be lifted and disabled people could not use the ablution facility.

In the Free State, the Department of Public Works failed to erect a field hospital at the show grounds. The hospital was scheduled to be handed over on the 1st of August 2020, but by the 15th of September 2020, the hospital was still not ready. According to the report, the hospital was never in use.

The FF Plus has warned government that its sole right to procure and distribute vaccines against Covid-19 could be problematic in light of the extensive corruption, in which various ANC politicians and officials are implicated, that occurred in 2020 with the procurement of PPE. The public has lost all faith in the government long ago already and it is hard to trust the undertaking by the Minister of Health to eliminate all fraud and corruption in the processes relating to vaccines by centralising those processes. The FF Plus is very sceptical about the Minister's statements on the matter. It offers absolutely no guarantee that corruption will not take place. Therefore, the private sector must be allowed to procure, store and distribute vaccines with the relevant regulations in place. The government cannot be the sole purchaser and distributor. In order to successfully roll out the Covid-19 vaccine programme, a publicprivate partnership must be established.

The state laboratories' facilities are not suitable for storing the vaccines below -70 °C and that in itself already poses a very big problem. It seems that the government wants to use the pandemic to prove that it can make a success of the NHI. It is, however, only achieving the opposite and its current conduct makes it clear that the NHI will end in disaster.

The involvement of GEMS, the Government Employees Medical Scheme, in corruption of nearly R300 million over a period of five years is a clear indication that the NHI fund will be looted and that GEMS cannot be trusted to be the administrators of the NHI.

The so-called "no-fault compensation fund" that was announced by the Minister of Health in April 2020 to address injuries related to Covid-19 vaccines raised many doubts about the South African health sector.

Before the Gazette with the final regulations for this fund was published, the public was given only four days to comment on the proposed regulations aimed at establishing the fund in terms of the Disaster Management Act. The said regulations were published on the 15th of April 2021 and the deadline for submissions from the public was the 19th of April 2021. It is unacceptable that the public participation process lasted only a period of four days while the public and affected organisations should have been given adequate time and a fair chance to submit their comments.

Taxpayers will be responsible for amassing the R250 million needed for the compensation fund, which is aimed at compensating people for injuries caused by Covid-19 vaccines, and, therefore, they have the right to provide input on how the fund will be spent. As stated, many times throughout this report, faith in the government is at an all-time low at the moment due to the corruption that occurred with the Covid-19 Emergency Fund and to steamroller such regulations by allowing just four days for public submissions is not only undemocratic, but also raises the question of why there is so much haste to established this fund? The hope that this fund will not be looted as well is very feeble indeed.

It is a given fact that the poorest South Africans bear the heaviest burden caused by corruption in the public health sector.

19. Conclusion: The Need for a Health Care System

It is abundantly clear that the NHI Bill cannot be implemented and that it is not the right nor correct way to provide health care services to nearly 58 million South Africans. A plan for a health care system, which incorporates both the private health care sector and the public health care sector, must be developed to ensure that all the medical professionals across South Africa work together to put such a system in place. It is not the government's responsibility to develop such a system, it is the responsibility of all the medical professionals who work extremely hard every day to keep South Africans healthy. Our country needs a system developed by medical experts and not politicians or government officials; a system that does not aim to destroy the one sector for the sake of the other; a system where politicians listen to the ideas of medical professionals in the private and public health care sectors; a system designed by doctors and nurses and passed as law by politicians.

The Freedom Front Plus rejects this Bill, The National Health Insurance Bill, in its entirety.

5. Committee Recommendation

The Portfolio Committee on Health recommends that the House adopts this report and approves the second reading of the National Health Insurance Bill [B11B-2019].

Report to be considered.