Freedom Foundation & Izwe Lami

8 Riley Road
Bedfordview
Johannesburg 2007
Email: info@freedomfoundation.co.za
Phone: +27 67 401 8589
Registration number: 2023/726599/08
PBO number: 930083077

Submission

on

Council for Medical Schemes (CMS) Report

on

Low-Cost Benefit Options (LCBOs)

by the

Freedom Foundation and Izwe Lami (FF)

16 May 2025

Contents

Logo art: Frances Kendall

1. Preliminary Comments

We appreciate and respond to the Honourable Health Minister, Aaron Motsoaledi's request for comment on the Report of the Council for Medical Schemes (CMS) on Low Cost Benefit Options (LCBOs).

The FF is a policy institute created by the founder of the Free Market Foundation, Leon Louw. As with all his work over more than 50 years, the FF is unambiguously non-partisan and politically unaligned. Its sole objective is to research, identify and encourage all role-players to implement best practice policies.

The Freedom Foundation (FF) emphasises its commitment to maximum quality healthcare for all South Africans and believes the central question is identifying the policies most likely to achieve this in the real world. As a non-partisan policy institute, the FF aims to promote best practice policies in every context

The FF is unique in that all other submissions are likely to be from, and promote, supply-side vested interests of healthcare product providers and/or the pro-bureaucracy vested interests of regulators. In contrast, this Submission promotes exclusively the demand-side preferences and interests of consumers and users of healthcare products and services, especially the poor.

We note that the Minister has spoken of the need to implement recommendations from the Healthcare Market Inquiry including the introduction of the Multilateral Pricing Forum (MLPF). We have made Submissions on this, and on the NHI Act, and do not address MLPF here but do reference NHI as an integral part of this discourse. We do, however, note that our MLPF Submission explained in detail why the creation of a collusive price control monopoly would be an extremely bad idea. And that for the Competition Commission to recommend collusion, monopoly and the prohibition of price competition is a surreal contradiction.

2. Conclusions

For ease of reading for policy-makers under time pressure, we adopt the unusual approach of summarising conclusions in advance, Full motivations are, of course, in the ensuing text.

The CMS makes two recommendations:

1. That LCBOs should not be introduced for medical schemes nor additional insurers, and that currently exempted insurance products offered by currently approved insurers should be phased out.
2. That LCBOs may be introduced subject to strict conditions.

Since these are mutually exclusive, they cannot be "recommendations" but are open-ended options. It is explained below why low cost options should be widely available to consumers, especially but not only, for the poor, without conditions, to enable them to make empowered and liberated life choices, and why we do not therefore support either recommendation.

Phasing out exempted insurance products without opening the market to free competition would ban access to vital low-cost healthcare for millions. The interest of all, especially the poor, are advanced by innovation and cost-savings driven by decriminalised competition.

The best interests of consumers are always actualised only in open competitive markets whereby suppliers are free to innovate, provide solutions and offer lower prices that best meet consumer preferences.

To deny the poor free access to low-cost private benefits is an ethical travesty.

Current policy discriminates against the poor and should be abandoned.

3. Abstract

The detailed Submission which follows highlights popular misconceptions upon which policies and recommendations might be based. As the saying goes, "*The trouble with people isn't their ignorance. It's the number of things they know that just ain't so*."

One of the most enduring examples is the myth that private care serves only 16% of the population (9.8 million people) and that the remaining 84% are served exclusively by government ("public" care). Why this is, to put it in the impolite terms it deserves, dangerous and anti-democratic twaddle is explained below. The obvious fact is that most people, rich and poor alike, purchase out-of-pocket healthcare. What real world people want and buy is low cost insurance, medications, consultations, traditional care (80% of the 'black' population), alternative care and the like,

Other examples are the myth that everyone receives or should receive only Western (allopathic or neo-colonial) care, and that consumers are inherently too ignorant or stupid to make orthodox and alternative informed healthcare choices.

According to the Statistics SA General Household Survey, approximately 30% of citizens initially look to the private sector for medical care before using the public sector. This represents more than 20 million people who pay out-of-pocket or have medical insurance policies. Recourse to sangomas and faith-based care is also common. In a free and democratic society, what real people want so much that they allocate extremely scarce resources to it, must be respected. Patronising policy is antithetical.

Most people favour and use traditional healthcare, medicine and herbalist providers. As many as 80% of the 'black' population use traditional care at their own expense in addition to government clinics and hospitals. If this is a 50:50 split, private care serves 42% of the population and the government only 58% (26.5 million people) as opposed to the mythical 84%.

According to Discovery Health, about 1.2 million people are covered by policies that enable them to access private sector medical services such as consultations with general practitioners, dentists, physiotherapists and psychologists. Momentum Health Solutions estimates there are 2 million beneficiaries of these policies. Other experts estimate that current unserved demand for health insurance products is more than 10 million people.

The regularly stated mantra of 16% accessing private care is blatantly false.

This Submission argues that healthcare beneficiaries have or should be recognised as having a constitutionalised "fundamental" democratic human right to freedom of choice, whether or not at their expense, especially the constitutional rights to bodily integrity, freedom of belief and access to healthcare.

The South African Constitution provides for the right of "access" to healthcare. This is often misconstrued as applying only to government provided and delivered care. The right to "access" healthcare, housing and constitutionalised rights includes, arguably more importantly, the right to *acquire* such benefits through purchase or self-provision, such as cultivation and building construction.

The conclusion reached herein, which it is argued is the appropriate conclusion for all who care about citizens, is that everyone has or should have a fundamental right to low and/or high cost benefits of their choice whether or not at their expense, and from a provider of their choice.

4. Summary of Key Concerns Raised by the FF

4.1. **Impact on Universal Health Coverage (UHC)**
The FF argues that preventing the poor from accessing healthcare through restrictions on LCBOs is at odds with the goal of UHC. Extending current exemptions for low-cost medical insurance to all players will provide immediate access to quality healthcare for low-income people without requiring legislative changes.

4.2. **Potential Increase in Out-of-Pocket Expenses**
The FF questions the CMS's assertion that LCBOs will increase out-of-pocket expenses, arguing that insurance, by its nature, reduces the full cost of services for individuals impacted by adverse events. That is why insurance exists and why its inherent virtue are appreciated in all other contexts. The right to insure against risk is or should regarded as a fundamental human right.

4.3. **Widening of Healthcare Inequities**
The FF challenges the idea that LCBOs will widen inequities, particularly for the "missing middle," suggesting their proposals address this concern and show how existing and extended LCBOs promote equality by making highest quality care accessible and affordable for lower-income people.

4.4. **Hindrance to National Health Insurance (NHI)**
The FF refutes the concern that LCBOs will disrupt progress towards NHI, counter-arguing that legislative changes for NHI itself could lead to fragmentation. We propose that extending exemptions could offer a more immediate pathway to broader coverage than waiting – for many years according to the Minister – for full (as yet undefined) implementation of NHI.

4.5. **Uncompetitive Environment**
The FF believes that continuing with current exempted products creates an uncompetitive environment and advocates for allowing all players the freedom to compete on price, quality, and service.

4.6. **Threat to the LCBO Sector**
The FF highlights a perceived "relentless attack" on LCBOs and low-cost medical insurance and emphasizes the importance of this sector. They suggest that extending exemptions or allowing open competition are crucial for its survival and expansion, and that this is in the very best interests of all, especially the poor.

4.7. **Impact on Universal Health Coverage (UHC)**
The FF submits that restricting access to healthcare for the poor through limitations on LCBOs contradicts the objective of UHC, especially what is fundamentally fair and just.

4.7.1. The CMS report discusses the necessity of medical schemes to provide low-cost benefit options, acknowledging the industry's good faith and sincere proposals to accommodate low-income individuals.

4.7.2. However, the CMS also expresses concern that the proposed industry package lacks sufficient benefits to address the burden of disease effectively. There is no single “package” but a wide range of options to suit everyone’s legitimate needs fully covering the burden of disease.

4.7.3. The HMI highlighted reduced access to benefits of private healthcare in South Africa as a motivating factor for the inquiry. The obvious solution is to remove regulatory barriers to full and free competition and thus access.

4.8. **Affordability and Out-of-Pocket Expenses**

4.8.1. The FF questions the CMS's assertion that LCBOs will increase out-of-pocket expenses, arguing that insurance reduces the full cost of services for individuals.

4.8.2. The CMS report acknowledges that the current benefit options are found to be unaffordable because the Medical Schemes Act has legislated the mandatory PMBs and the payment of PMBs claims by the medical schemes is compulsory and expensive.

4.8.3. The HMI also identified high and increasing expenditure as a motivator for the inquiry.

4.9. **Healthcare Inequities**

4.9.1. The FF contends that LCBOs can address inequities, particularly for the "missing middle," while the CMS suggests that introducing a new option for the missing middle widens inequities in healthcare access.

4.9.2. The CMS report highlights the importance of addressing the burden of disease and ensuring equitable access to healthcare.

4.10. **National Health Insurance (NHI)**

4.10.1. The FF argues that LCBOs will not disrupt NHI progress, while the CMS expresses the need to preserve and protect the implementation of the NHI.

4.10.2. The CMS report discusses policy analysis in relation to the National Health Insurance.

4.11. **Competition and Market Dynamics**

4.11.1. Current exemptions create a healthy competitive environment because of the proven and universally recognized virtues of open competition. The CMS concern is unexplained and unwarranted. The current exemptions are obviously pro-competition. There is no known reason in competition theory to the contrary.

4.11.2. The Competition Commission’s Health Market Inquiry (HMI) suggested concentration, market power and uneven bargaining between sector players. They should therefore, as a competition commission, have recommend market liberalization.

4.12. **Sustainability of Medical Schemes**

4.12.1. The CMS report acknowledges the medical schemes industry argument that the number of medical scheme beneficiaries has not grown significantly in the past ten years or more and this poses a sustainability threat to the medical scheme industry.

4.12.2. The report also delves into the development of low-cost benefit options within the medical schemes industry study.

A pro-consumer and human rights approach is needed to promote affordability and equity, as well as medical schemes and insurer sustainability. This will enable the country to progress towards UHC.

5. History

We have produced a full history of developments since 2015. That is the year from which PMBs and LCBOs have been under consideration in earnest. It also happens to be the year from which all policies and laws must be preceded by a fully compliant prescribed socio-economic impact assessment (SEIA). A compliant SEIA must quantify the problems to be solved, also known as the “mischief principle”, as well as promised costs and benefits. Since none has been concluded, the recommendations may not be implemented pending a SEIA.

Compliant SEIAs in healthcare have not been undertaken since 2015.

In the absence of rigorous analysis and monitoring it is no surprise that the healthcare market has been characterised by contradictions and anomalies (specified below), along with uncertainty and confusion especially amongst consumers.

6. Why the Government Should Celebrate Private Healthcare.

It is obviously rational for all who favour universal healthcare to celebrate and maximise all and any private cover or care. There is a strange if not perverse notion that private care should be discouraged, even prohibited, as part of "full" implementation of National Health Insurance (NHI). We have been unable to find a single justification for this seemingly incoherent view.

What renders a maximal private sector virtuous for all is blindingly obvious, namely that every cent spent on private care is a cent more available for public care. The more of their own money people spend on themselves the more of other people's money is available for public care.

This is so obvious that everyone takes it for granted regarding, for instance, housing.

"Full" NHI for 100% of the population at government expense might cost the estimated R1 trillion. But if 50% of the population fund their own care, that would liberate enough for the government to double the quantity and quality of care for the population who cannot afford to self-fund.

The obviously rational decision for the government is to make it maximally easy for people to acquire whatever care they wish at their own expense. Apart from allowing freedom of choice, the government should go further and subsidise private care for those who cannot afford it (based on a means test), so as to minimise the burden on public healthcare.

The government should do all in its power to liberate self-funded low *and* high-cost care to lessen the burden on and improve the quality of whatever care is offered by the government. In other words, it should follow the principle it follows *in every other context*. The greater the number of people who house themselves, for instance, the fewer RDP houses government must provide, and the more luxurious RDPs it provides can be, including the full range of quality social and physical infrastructure, services, roads, amenities and the like. The more people who earn private incomes, the more government is free to increase social grants. Private education lessens the government's education burden. The more electricity people generate for themselves, the easier and cheaper it is to supply the rest. And so on.

By far the biggest and most obvious beneficiaries of private care are consumers. The second is government. The third is superior quality private enterprise.

This is especially true of LCBOs but also true of high-cost options. It makes no difference what the cost might be, nor how many opt for it. Any number, however big or small, is to be celebrated.

7. Low-Cost Benefit Options (LCBOs)

The emphasis is on "options". The purpose of LCBOs was to provide for the option - the right and freedom – of choice for lower-income people to purchase cover at their instance and expense. Much has been said, including by the Minister in his Call for Comment, about supposedly there being no need for LCBOs because "the benefits being proposed for the

LCBOs are less than the current benefits package offered at no charge by the public healthcare system."

This reflects a profound misconception about the nature and purposes of freedom of choice. The misconception is that there is no need for this option because (a) everyone is entitled to free government healthcare and (b) citizens are incapable of making rational decisions about their own lives and resources.

As stated above, quite the opposite is true in a free society and democracy. Our constitution is based on the principle that citizens are not only capable of making sensible decisions, but are fundamentally entitled to do so.

8. Concerns raised by Minister Motsoaledi

In his call for comments, the Minister mentions objections to low-cost insurance that he would like to be addressed in Submissions. The extent to which these are his personal views or merely drawing attention to the concerns of others is unclear. Given the incoherence of some of the objections we trust that they are not the Minister's and that he mentions the concerns of others in order to have them refuted. By implication the objections oppose *all* low-cost insurance not merely narrowly defined LCBOs.

8.1. **"Firstly" LCBOs offer less than 'free' public healthcare**

If true, it would be a virtue to celebrate since (a) it would ease the public sector burden, (b) empower and liberate healthcare beneficiaries with freedom of choice, and (c) recognise the constitutional right to bodily integrity and the right to access healthcare of choice.

It is unclear what might be objectionable about the right to acquire the proposed benefits voluntarily with one's own money and choice as opposed to being forced into a government monopoly at other people's expense.

It is, "difficult to reconcile why a low-income earner (the target group for this package) would purchase such a package when the same is available for free or at a nominal charge from the State."

Since this is what already happens, there is nothing to "reconcile".

Maybe the idea is that people spending their own money on their own lives are too ignorant and stupid to realise their presumed folly.

Under the recommended low-cost option, there might well be a right to fewer services than are available under public care, regarding which there are three obvious responses:

8.1.1. What LCBOs may be offered should be unlimited.

8.1.2. Whatever might be available is preferable to prohibition. It is unethical to ban anything that increases the right to enhanced personal health.

8.1.3. Medical Aids and insurers offer and charge for what public healthcare offers, yet millions of people willingly pay for what they offer. This suggests that people know that they will always have public care but make the choice to pay extra to have faster and better options for freely and rationally valued purpose.

This objection is as irrational as objecting to someone paying for a room in a private house when rooms in RDP houses are free.

It is also as irrational as objecting to the extremely wide range of home, business and vehicle insurance options. People are offered and are free to choose all or zero offerings. People may buy anything from comprehensive vehicle insurance to hail or 'ding' damage. A home owner may insure anything from comprehensive household insurance to a single painting. And so on.

The objection reflects a failure to appreciate the essentials of economics. Amongst the purposes of competition are innovation and diversity of consumer choice. It is essential for LCBOs not to be "comprehensive". The idea that they should, misconstrues the idea completely. A low-cost offering might be for a single telephone consultation per year or "comprehensive" healthcare mentioned by the Minister. It should be noted no one has the slightest idea what "comprehensive" care might mean.

No insurance or government offers everything that medical science has to offer. Freedom Foundation statistician, Garth Zeitsman's research found that truly comprehensive care – the equivalent of unlimited care in the US – for every South African would cost more than the entire R7 trillion economy (GDP).

Another objection raised by the Minister is that the cost would not be low enough for the poor. Were that true – it is obviously not – there would be no need for concern because, if so, no one would purchase LCBOs. That fact they already do and will do so increasingly if liberated, is conclusive proof that LCBOs are necessary and desirable.

Tere is only one way to cut costs and that is through competition. This is why the LCBO market should be totally liberated. Free competition drives prices down, increase freedom ofchoices, drives innovation and improves quality (see below).

The Minister is concerned, but need not be, that low-income earners - the target market for these products - should be banned from exercising the informed and democratic right to use their own money to buy anything that the government offers. *That is as irrational as prohibiting private gardens because there are public parks, or having a private pool when there are public pools.*

The concern about employers being induced to support LCBOs for employees is also unfounded. Employers should be free under labour relations law to agree with employees and bargaining councils regarding contributions towards agreed LCBO packages whether or not they offer fewer benefits at higher cost than supposedly – although not really – identical public healthcare offerings. In doing so all concerned should be free to exercise control over their own money and bodies.

The idea that public healthcare is free is, of course as all economists know, a myth. There is no such thing as a free benefit. The only issue is who pays. Private care is paid for by recipients of the care provided whereas public care is paid for by others. Private care is generally of superior and better value, which is commonly mentioned by advocates of the NHI. They tend to do so as if that virtue is a problem. In truth, it is a solution.

A fully implemented (yet entirely undefined) NHI is no solution to healthcare inequality, except to the extent that it would ensure equally low-quality care for all. Only private care generally including LCBOs, medical insurance and freedom to choose alternative providers can ensure better quality care for most if not all people. Liberated markets will enable more and more people, especially low-income people, to acquire ever-higher quality care.

What is to be celebrated by all of those who care is the principle of self-ownership and choice. Healthcare is arguably the most important aspect of life. Anything that prohibits

freedom of choice violates one of our most cherished "fundamental" constitutional rights, the right to bodily integrity.

The following table compares public health with current – emphasis on *current* – LCBOs. Far from suggesting a need to eliminate the latter, what the table demands is to liberate it.

It should be noted that the table is debatable in that most or all of the items in the PHC column might well already be available under LCBO offerings.

The reason why more is not available at lower cost is regulation. LCBOs and making them comprehensive, will enhance what is offered on both sides. More in the second column would liberate more scarce healthcare resources for the first column.

Table 12: Comparison between the proposed LCBO minimum package and the PMB PHC package

PHC Service Package	Included as part of the LCBO minimum benefit
Preventative Services	√
Maternal Health Services	√ (very limited)
Neonatal & Child Health Services	√
Mental Health Services	**X (except for screening)**
Rehabilitative & Palliative Services	**X**
Radiological & Pathological Services	√ (basic)
Oral & Eye Health Services	√ (limited)
Procedure/Surgical Services	**X**
Essential Drugs, Devices & Consumables	√ as per the EML

CMS comparison of Public Healthcare (PHC) prescribed minimum benefits (PMBs) with Low-Cost Benefit Options.

8.2. **"Secondly" LCBOs are presented as "medical scheme like" and are not researched**

The proposals are "not supported by any research linked to the specific sector of the population that believe these products offer a real value given the minimalist benefit package and significant cost."

No coherent reason is given for this concern.

8.2.1. The assumption that only low-income people want low-cost options is obviously fallacious. Everyone wants low-cost options in every aspect of life.

LCBOs are *not* for a "specific sector". Medical schemes are banned by PMBs from offering low cost options to rich and poor alike. The victims are overwhelmingly the poor. Their only current affordable option is LCBOs.

It is essential for policy-makers to appreciate that the prohibition of the full range of possible LCBOs impacts the poor in precisely the same way that they would be impacted by the prohibition of cheap clothes and food.

What all decent people want is for the poor to have free access to cheap products and services especially healthcare. The only way to maximise their well-being is to maximise free competition amongst providers. In every sphere of life, free competition drives innovations, lowers prices, provides more choices and achieves greater equality.

To deny the poor free access to low-cost private benefits is an ethical travesty.

Current policy discriminates against the poor and should be abandoned.

8.2.2. That there is supposedly no "research" is clearly untrue. There is constant research undertaken by medical insurers and medical schemes. Market research is a routine and essential aspect of any business.

8.2.3. In any event, no research of the kind presumably envisaged is necessary to ascertain the obvious, that poor people want low-cost options. Of course they do. There is no purpose served by researchers walking around asking, "Would you like the right to buy low-cost health cover." No one is stupid enough to say, "No thanks, I don't want choices."

The assumption that the low-income population believe mistakenly that "these products offer a real value" is, with respect, demeaning and insulting. The only person with sufficient knowledge of their unique personal circumstances to make an informed decision is the person concerned. No one else is ethically or logically entitled to make one-size-fits-all decisions, especially not for the poor.

Nobody is more cognisant than a poor person of the value of every cent. They have innumerable ways in which to spend their scarce finances. They and they alone are best-placed to choose between new shoes and a visit to a doctor. No caring person can, with a clear conscience, deny them that right.

They are also the only person who should be empowered and liberated to choose between supposedly free public care and supposedly expensive private care.

The Minster added that LCBOs are presented as "medical scheme-like products", and only when clients "attempt to access the benefits do they discover that their options are extremely limited."

It is unclear what "medical scheme-like" means. What they have in common is, of course, that they are for healthcare. When someone buys insurance cover or joins a medical scheme they might well think of them as similar. And they are. Both are cover for similar purposes.

But, so what? Why does it matter? Of what relevance might it be?

The CMS made the clear distinction that LCBOs are (for the most part) primary healthcare insurance products, and not a membership of a medical aid scheme. They added that, by virtue of the similarity, and the exorbitant cost of PMBs, LCBOs might pull funding away from schemes and damage them over time.

Far from rejecting the extension of LCBOs, the market should be liberated in the interests of consumers, especially (but not only) the poor.

8.3. **"Thirdly" LCBOs are profit driven**

Far from the LCBO profit motive being a problem, it is a cosmic virtue. It means that healthcare does not drain the public purse, and that providers (unlike public sector counterparts) are incentivised to cut costs and be efficient.

The private sector is driven by the profit motive to attract as many customers as possible and serve them so well that they return. The loss motive incentivises people in the public sector to serve as few people as possible and for them not to return. This is part of the 'secret' behind why the poor want LCBOs. Public Choice School economists call such negative public sector incentives "perverse incentives".

The "proposal was developed by the private healthcare sector with the purported objective of offering a package of services at an affordable rate for low-income earners."

Medical insurers offer the same. It is not a "purported" objective, it is the way to attract low-income earners who, as the Minister observes, have free access to public healthcare. For them to prefer spending their hard-earned money on private care indicates how dissatisfied they are with public care.

"Implicit in this (LCBO) objective is for such a service package offering to be comprehensive."

No, there is no such implication. On the contrary, the most distinctive feature and virtue of LCBO market is that there are specific narrowly defined and tailormade offerings. Implicit in this objection is the false notion that medical scheme options are "comprehensive". Far from it. There is a range of packages, as there should be.

It is also implicit here and in the other objections that the government offers "comprehensive" care. It is far from comprehensive. There is a great deal of care, especially that of the latest technological and costly variety , that the government does not offer. It cannot and should not offer nor pretend to offer "comprehensive" care.

8.4. **"Fourthly" there is a lack of detail**

"The LCBO package proposed in the report lacks detail on exactly what services will be offered or the quantity of each benefit e.g. the number of consultations permitted etc."

This is an extraordinarily strange objection. It suggests a complete lack of understanding about the essential nature of LCBOs. There is no, and should never be, a single "LCBO package". The distinguishing feature of LCBOs is a wide range of offerings, the wider and more varied the better. Nothing could be more alien to the LCBO concept than the idea that there could be one mandated "package [with] detail on exactly what services will be offered". More detail could have been provided by observing the range and detail of the current offerings on the market. The final report does not appear to have considered these.

What consumers demand is indeed detail but of a profoundly different nature, namely detail on the very specific option from which they select according to need and preference. They demand the right to buy cover for anything from one "consultation" to hundreds, for which they choose to pay accordingly.

"This information is important for consumers so they have a clear understanding of the LCBO. Permitting this level of vagueness may lead to the development and sale of products with minimal benefits."

Existing consumer protection law and practice, as well as financial service laws and practices are very exacting. For instance, full recorded details must be and are explained to every consumer to ensure informed consent. The current Market Conduct Authority and of accountability of providers fulfil this obligation.

On the other hand, a single globular package would be "vague" and fail to address the unique needs consumers as required by financial product law.

Should the government become aware of anything vague regarding an LCBO it may and already does act according to tried and tested laws. Anything misleading has been criminalised as fraud and negligence for centuries.

As for products with "minimal benefits", they should absolutely exist. Free competition and enterprising innovation will ensure that they also have "minimal" cost.

There is a bitter irony in the "vagueness" objection, which is that nothing could be vaguer than the NHI. No one, not even the Minister or DG, has the slightest idea what will be done under the law nor when it will be done. The Health Department built and enacted an entire prospective rebuilding of healthcare through the NHI Act with none of the details demanded of LCBOs. NHI is vague almost beyond imagining. As the Minister of Finance observed, there is not even a budget, and no concrete actions and timelines are specified. Not even "healthcare" is defined.

A major point of contention over the NHI is that it will ban medical schemes from offering anything done by the government, which has plunged the entire healthcare sector into uncertainty because there is no idea – apart from educated guesses – which services it will be offered, or when. It is unclear, for instance, whether private practitioners will be allowed because everyone is free to visit a clinic or hospital, or whether pharmacies will be allowed because they exist at state hospitals.

Another paradox is that the National Health *Insurance* Act is the opposite of insurance. It prohibits insurance, as suggested by the Minster's objections. LCBOs *are* insurance and should be welcomed under an "insurance" act. For the name of the act to be coherent, the endorsement and promotion of LCBOs should be its single most prominent feature.

This is so fundamental as to bear repetition. The only way for the inclusion of "Insurance" in the name of the NHI Act to make sense is for LCBO and other healthcare insurance to be more than permitted; it must be promoted as a defining feature of healthcare law and policy.

Indeed, true health insurance would be for the government to hand all healthcare facilities to existing managers and employees under share option schemes (ESOPs) and for the NHI Fund to pay insurance premiums for those who cannot afford insurance. LCBOs should be elevated to the primary means of fulfilling the NHI *insurance* promise.

To the extent that any conclusions can be drawn from the NHI Act, they suggest the immediate prohibition of private practitioners, pharmacists and hospitals. That fact might be dismissed as an exaggeration, but it is the literal meaning of the law as it stands. Enthusiastic support for LCBOs would be the right thing for the government to do.

8.5. **"Fifthly" the Recommendations are not aligned with the NHI**

"The NHI Act sets out a clear pathway towards universal health coverage and the reforms that are envisaged."

As explained above, this is decidedly *not* so. "Alignment" is therefore impossible.

There is neither a "clear pathway" nor clarity on what is meant by "universal health coverage". By saying that comprehensive healthcare is already provided by government, the Minister states correctly that there is already "universal coverage". Nobody knows which "reforms" are envisaged.

Until there is a clear pathway, including timelines and changes, what would be most consistent with NHI and most effectively advance it would be for LBCOs to lead the way.

"There is no clarity on the alignment of these policy proposals with the NHI Policy."

On the contrary there is as much clarity as is possible at this stage. The proposals favour low-cost insurance, which places them in full "alignment".

It could be argued that "alignment" is impossible since it is not known what will happen under NHI. This presents an insoluble conundrum. Either the only way for the LCBO proposals to "align" is for them to be banned in toto because they offer what will purportedly be done under NHI, or unrestrained LCBOs should be allowed. The latter is more sensible and generous to the public, especially the poor.

9. Response to CMS Recommendations

The CMS is a statutory body, which reports to the Minister of Health. Hence we assume that the Minister's objections as above, might reflect the views of the CMS. It is, as stated, unclear whose concerns the Honourable Minister listed. Therefore, we now address (below) only those we have not covered above in in full in our itemised (seriatim) response to the Minister.

9.1. **"Insufficient benefits"**

"*The package proposed by the industry lacks sufficient benefits compared to the CMS package. The insufficient benefits may hinder the effective management and coverage of the burden of disease among beneficiaries*."

Addressed above.

The current medical aid scheme (MAS) regime is unaffordable to most citizens because PMBs which discriminate, perhaps unconstitutionally, against middle and lower income groups.

Most people lack the resources to afford MAS options and are forced by law rely on state hospitals and clinics many of which are incontestably inefficient and badly run. Allowing LCBOs will go some way to alleviating this problem *at no cost to the government*.

Not allowing LCBOs would mean the poor will be denied just coverage in any meaningful sense.

9.2. **No guarantee that LCBOs will reduce the burden on public healthcare**

"There is no guarantee that introducing the LCBO will significantly reduce the burden on public healthcare services."

Addressed above.

This is, with respect, a misinformed if not nonsensical concern. As the CMS well knows (or should know) LCBOs are already doing so, and if liberated from needless strictures, will do so to a substantially greater extent.

That aside, there are two possibilities (a) that they will not do so and (b) that they will. If the former, the CMS concern is unfounded because the public healthcare burden will be as apparently desired by NHI advocates.

If the latter, the CMS will celebrate the reduced public burden,

In any event, neither natters, The issue is the fundamental right for people to decide for themselves: to run their own lives.

Also, as explained above, every cent paid for private care, however little or much, by rich or poor, reduces the public burden. Currently unsatisfied demand is exceeds 12 million people who would otherwise use public sector services but are willing to pay for low-cost options. Employers, who cannot afford medical aids, are increasingly offering just, fair and negotiated LCBO benefits to employees.

9.3. **LCBOs undermine PMBs**
"*The LCBO will undermine the PMB dispensation, which ensures that all scheme members receive essential medical services.*"

It is PMBs which make MASs unaffordable and out of reach of the majority. This imposed high cost is preventing lower-income people from accessing medical scheme healthcare and contradicts the stated desire for universal health coverage.

LCBOs are the angelic saviour for people driven by regulation from MAs.

9.4. **LCBOs are likely to increase out-of-pocket expenses.**
"*The LCBO is likely to increase the out-of-pocket expenses paid by individuals*."

This concern suggest a basic misconception about what insurance is. By its essential nature insurance replaces out-of-pocket expenses. That is what Insurance does.

For a premium of Rx the insured gets coverage of multiples of Rx.

Insurance means that most insured people are spared the full cost of services in every sector of the economy. In unfortunate mishaps against which people are not insured, they are forced to use public and/or out-of-pocket care.

The more rational concern for the CMS would be to anguish about who does not have LCBOs than who does.

9.5. ***LCBO could widen the inequities***
"*The LCBO could widen the inequities in healthcare access, particularly among the 'missing middle'*."

This is profoundly mistaken as explained fully above.

LCBOs have precisely the opposite effect for obvious reasons. They provide just and equitable access to the "missing middle".

9.6. **Complexities that could hinder NHI**
"*The LCBO may introduce complexities that could hinder or disrupt the progress towards implementing NHI*."

Addressed above.

Since LCBOs have nothing to do with whatever course NHI might take – that is presently unknowable – they could not possible complicate nor disrupt anything.

All they will do is make NHI implementation easier and cheaper.

Even if NHI entails nationalisation and/or prohibition of medical scheme and health insurers, as extremists believe it should. LCBOs pose no problem, They will simply be nationalised or banned as and when the minister at the time directs.

9.7. **LCBOs require legislative changes that will fragment universal coverage.**
"*The LCBO will require legislative changes that will engender fragmentation as opposed to universal coverage*."

Since the existing exemptions never required legislative changes, extending them will not. Making them permanent, as they should be, will respect existing cover and rights and grant immediate access to low-income and all citizens without any legislative changes.

9.8. **Continuing exemptions will create an uncompetitive environment**
"*Continuing with the current exempted products will create an uncompetitive environment*."

Addressed above.

This another curious concern. It is unexplained and, with respect, incoherent. Surely everyone knows that a public right to more products is *more* competitive?

LCBOs allow all players the freedom to compete on price, quality, product range and service, as in every other sector

10. Final Summary of the Freedom Foundation's (FF's) Recommendations

10.1. **Extending the Current Exemption**
The Council for Medical Schemes should extend and enhance the current exemptions for low-cost medical insurance products to all market players. The exemption should be permanent. It can obviously be repealed or amended in the unlikely event that it becomes desirable. This will give immediate access to low cost healthcare for millions without legislative changes which cause needless delays.

10.2. **Promoting Competition**
The government should encourage a regulatory environment that fosters competition among healthcare providers and medical schemes based on price, quality, and service.

10.3. **Avoiding Fragmentation**
We caution against regulatory changes that could retard rather than promote universal coverage. Al the evidence and logic suggest that LCBO restrictions or prohibition would be counterproductive.

10.4. **Focusing on Immediate Access**
We stress the enormous potential for LCBOs to provide immediate healthcare access to a broader population, particularly while the NHI is being developed, defined and implemented.

----------oooOooo----------