31 May 2016

Ms MP Matsotso
The Director General: Health
Per email: nhi@health.gov.za

Dear Ms Matsotso

WRITTEN SUBMISSION ON THE WHITE PATER ON NATIONAL HEALTH INSURANCE
NATIONAL HEALTH INSURANCE: TOWARDS UNIVERSAL HEALTH COVERAGE

This submission is made on behalf of the founding members of the South African NCDs Alliance (SANCDA).

Its SANCDA's mission is to stop the epidemic of non-communicable disease (NCDs) by civil society activism and intersectoral collaboration through its NCDs Network.

This submission is supported by our meeting with the Deputy Minster, Dr J Phaahla in December 2014[1] [2]and in the NCDs Report card.[3]

Yours sincerely,

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SA NCD ALLIANCE
Stopping the epidemic of non-communicable diseases

Supported by the NCD Alliance and made possible by a generous grant from Medtronic Philanthropy
Founding Members

[1]Draft Minutes of the meeting 11 December 2014 https://goo.gl/tVRCNq
[2] NCDs Resolutions for health systems strengthening action November 2014 https://goo.gl/tVRCNq
[3] *Civil Society Status Report 2010-2015: Mapping South Africa's response to the epidemic of NCDs https://goo.gl/tVRCNq*

NATIONAL HEALTH INSURANCE: TOWARDS UNIVERSAL HEALTH COVERAGE

South African NCDs Alliance

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TERMS

DCSTs	District Clinical Specialist Teams
ICSM	Integrated clinical services model
ICRM	Operation Phakisa Ideal Clinic Realisation & Maintenance Programme
NCDs	non-communicable diseases
NHCom	National Health Commission
NHI	National health coverage
OHSC	Office of Health Standards Compliance
¶	paragraph number in the White Paper.
PHC	primary health care
SANCDA	South African NCDs Alliance
SDGs	Sustainable Development Goals
UHC	Universal health coverage

DEFINING NHI AS A SOCIAL INVESTMENT (¶ 57)

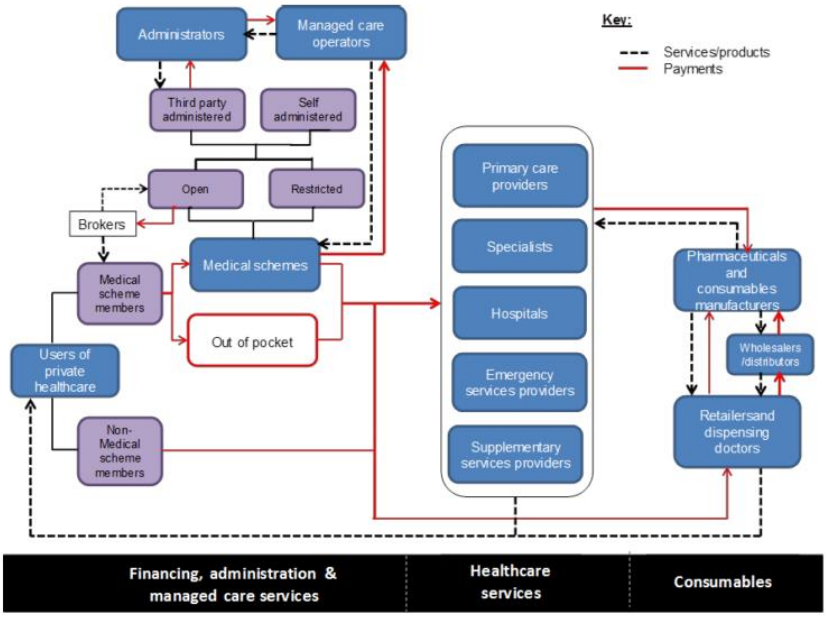
National Health Insurance for South Africa: Towards Universal Health Coverage,(1) hereafter referred to as the "White Paper" was released for comment to interested parties in December 2015.

This commentary on the White Paper is framed from the perspective of people who use the public health system and are to be the beneficiaries of the proposed National Health Insurance (NHI.) These men, women and children require personal health services from the state now and in the future. Therefore, NHI represents an operationalisation of the concept of universal health coverage (UHC) for the citizens. The citizens (people, users, patients, community) include individuals and groups from civil society and non-governmental organisations and are not necessarily legally South African by nationality. The SA NCDs Alliance (SANCDA) has already stated its unequivocal support for UHC at the highest levels.(2)

The purpose of this commentary is to include consideration of the White Paper that moves toward a common understanding that includes a "person-centred approach." Its objective is to ensure that a collaborative social accountability framework is incorporated into the NHI planning, systems and processes. This approach is embodied in the citizen-driven accountability framework which is aligned to a collaborative person-centred and civil society perspectives.(3) The citizens' voice must be heard in response to the White Paper because it sets the framework for a "massive shift in policy and service delivery."

For patients a major concern is that the White Paper unequivocally defines NHI in terms of a financial system focussing on financial-risk protection by the pooling of funds. It implies a causal relationship between financial security and improved health outcomes measured by improved personal health services. (¶ 1-2) Personal health services are further defined with mainly financial features. (¶52) However, these health services are also linked to principles within the of domain human rights as enshrined in Section 27 of the Constitution. (¶5) It is apparent that NHI is aligned with the characteristics of universal access including equity, evidence and quality of health care determinants. (¶ 53-59) The NHI also meets the requirements of the Sustainable Development Goal (SDG) 3.8 to ensure healthy lives and promote well-being for all at all ages by 2030. Finally, it is also seen as a social investment for the public good. (¶ 48, 57)

Despite all of these important acknowledgements there is a perceived failure to include a second equally weighted framing of NHI in terms of social investment and accountability. This is clearly an unintentional omission but is keeps the NHI conceptually stuck to a market-driven mode which it seeks to avoid. (¶5) This default position means that citizens are excluded from direct "ownership" of the health system and remain part of the ongoing commoditization. Control and ownership thus belong to the institutional financers of healthcare. Figure 1 represents schematic view of the market-driven private health sector from the Competition Commission's Market Inquiry into the Private Healthcare Sector.[4] It highlights that the people who pay for and use the health private health system are seen as part of the financing, administration and managed care services. By defining NHI in financial terms there is little conceptual difference as the "users" of the private system. If we fail to heed this caution, then citizens remain trapped as a commodity in an economic definition. (4-6)



Source: Genesis Analytics, 2012

Figure : flowchart of healthcare sector markets in South Africa (4)

To implement NHI a "huge policy shift that will necessitate a massive reorganisation of the current health system." (¶ 2) Elsewhere this change is called transformation "of health service delivery and management, particularly to improve the quality of health

[4] http://www.compcom.co.za/healthcare-inquiry/

services in both the public and private sectors." (¶ 431) This transformation must include the way in which the people who use the system are treated in terms of personhood and accountability.

> *UHC beyond 2015 must start and end with people. Listening to different experiences with illness and specific needs in all contexts, learning from other countries—not only those who have excellent services and 100% coverage, but also from national programmes that have given users of health services a role in accountability—will mean that strong responsive systems can be built. Health can then be claimed as the universal right that post-2015 generations can fully deliver on. (7)*

Citizens want a personal health system that is responsive to their needs and that provides services which are accountable to them. That is, social accountability for the people, by the people. So it is of concern that this transformation is well underway without the citizens being afforded consistent, equitable and transparent consultation. This system is, according to the National Development Plan, supposed to be people-centred. (8) An example of this is the ongoing re-engineering of primary health care (PHC) which lacks social accountability and transparency. This is addressed further in later sections.

NON-COMMUNICABLE DISEASES AND NHI

This commentary is also framed by the people who live with one or more with non-communicable disease (NCD) For example, diabetes, cerebrovascular disease, cancer, respiratory conditions and mental illness. The burden of disease is great upon us, our families, communities and society as a whole.(9) The mushrooming burden of NCDs is a global problem and low- and middle-income countries such as South Africa are particularly vulnerable.

The 2014 mortality statistics show NCDs to be the leading cause of death in South Africa having displaced communicable diseases as the top category of disease.(10) It is recognised that mortality statistics are incomplete and that full burden of disease analysis takes considerable time.

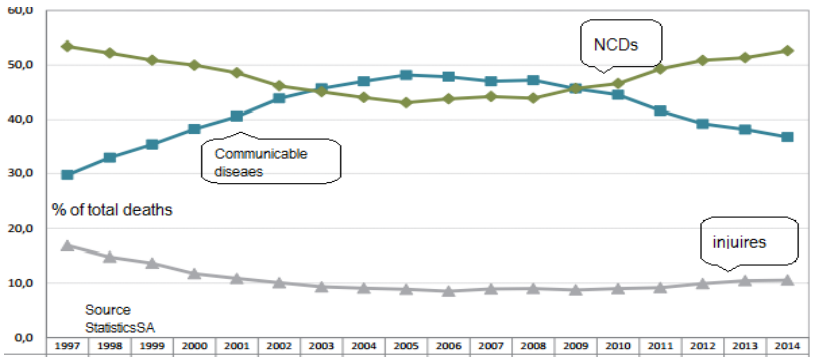


Figure : Percentage of deaths due to communicable/perinatal, NCDs and injuries 1997-2014

NCDs may occur at any age with a significant number being present at birth. Not all NCDs are due to lifestyle nor are they disease of the rich. Many treatable congenital conditions (of variable cost) and childhood cancers can last into adulthood.

It is understandable that a significant part of the research and planning that underpins the current White Paper took place in the era surrounding AIDS denialism. This terrible societal and health epidemic has shaped all aspects of health: policy, planning, financing and provision of care. Today South African has an antiretroviral (ARV) treatment programme that is justifiably globally applauded. However, that being said prevention still remains elusive especially among the young adult population and TB remains stubbornly problematic.

We, those living with NCDs, do not wish to be seen as making it an either or choice for NCDs or HIV/AIDS prevention, treatment and research. Both must be considered as part of the whole SA population. Neither is more or less stigmatised. However, the people living with NCDs demand and deserve equity. Sadly, some people living with NCDs perceive that it would be better to have HIV/AIDS. People living with HIV/AIDS are more likely to survive thanks to accessible healthcare and more especially ARVs.

These citizens will die of old age "with HIV but not of HIV.[5]" NCDs are the most likely cause of death from the age of 40 onwards as shown in Figure 3. The longer one lives, the greater the chance of death and disability from a NCDs.

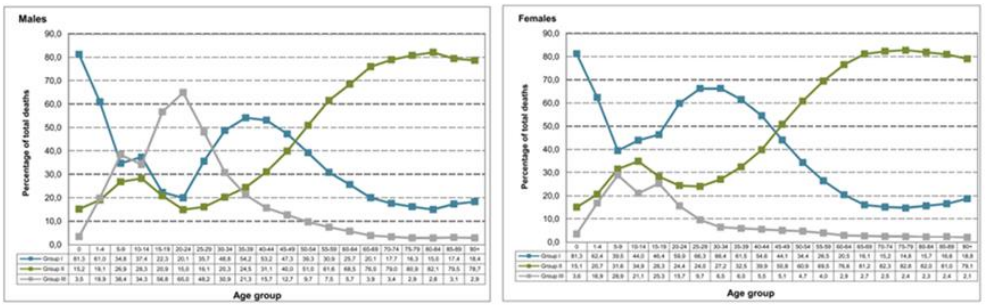


Figure : Percentage distribution deaths by age and gender due to communicable (Group I), NCDs (Group II) injuries (Group III)

The NHI and all of its related changes have to occur within the framing of the quadruple burden of disease

- NCDs (Group II)
- HIV/AIDS and TB (Group I)
- Maternal and child mortality (Group I)
- Injuries and violence (Group III)

This quadruple burden is acknowledged in the White Paper. However, we ask that further consideration and research is given to the major policy shifts and changes to a PHC system that is based on an HIV/AIDS model of care, the "integrated clinical services model." This model forms the foundation by which NCDs and all other types of illnesses are being "integrated" into HIV/AIDS treatment model.

> *Integrated clinical services management (ICSM) is a health system strengthening model that builds on the strengths of the HIV programme to deliver integrated care to patients with chronic and/or acute diseases or who came for preventative services by taking a patient-centric view that encompasses the full value chain of continuum of care and support. ICSM will be a key focus within an Ideal Clinic. (11) p.3)*

Operation Phakisa Ideal Clinic Realisation Programme (ICRM) is supported by global donor funded programmes and appears to lack social accountability. It is clearly stated that the ICRM is based on the ICSM which is predominantly sponsored by AIDS related donor funding and shaped by its employees.

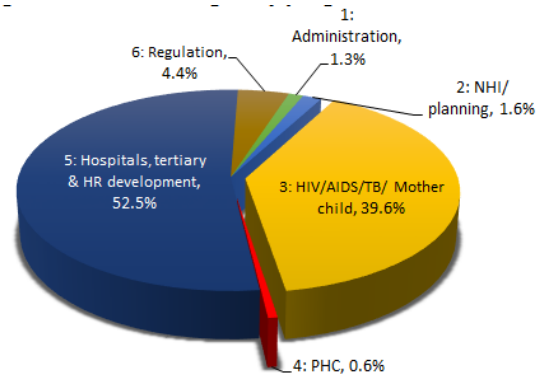


Figure : Health budget by programme 2015-16

Figure 4 shows the budgetary inequity in the 2015-2016 Annual Performance Plan. (12) This extends to the provincial levels. It also included the nurse initiation of ARV therapy (NIMART) by those with special training. (13) The same consideration has sought for decades by those who manage NCDs and who have further training.

We ask for social accountability into ICSM with high quality SA evidence to show that it has been sufficiently adapted to fit into the ICRM. NCDs cover a hundreds of disease entities encompassing vast array of knowledge and skills.

In 2014 the SANCDA called for its ongoing involvement NCDs-related initiatives irrespective of which NDoH programme or cluster is responsible for the implementation. This was with a view to collaboration framed from a citizen accountability perspective. It

[5] Tweet Treatment Action Campaign tweet quoting Mark Nelson https://goo.gl/vaF8dF

noted that critical initiatives occurred outside of the ambit of the NCDs sub-programme and NCDs civil society has not been included.(2) We asked for the urgent development of a communication and consultation mechanism to inform, involve and seek feedback on initiatives. It is suggested that this is a national version of WHO's Global Coordinating Mechanism for the prevention and treatment of NCDs (GCMNCD) and may flow out of the National Health Commission (NHCom.) (See page 7)

Sufficient transparency and communication at all levels on developments and progress including:

- The chronic care model and its later iterations (ICSM) based on the WHO chronic conditions model;
- The "Ideal Clinic" and Operation Phakisa at a PHC level and its iterations;
- Educational material including implied national clinical standards e.g. Primary Care 101;(14)
- Healthy lifestyle programmes;
- Referral systems between different levels of care for patients;
- Essential medicines list and standard treatment guidelines.

QUALITY MANAGEMENT AND STANDARDS

Since 2014 the SANCDA has called for NCDs prevention and treatment to be co-ordinated and managed at a national level and updated regularly according to international norms. The standards, guidelines and processes that are used for NCDs prevention and treatment and their integration into primary health care have a major role in determining policy. Naturally this applies to all conditions. We reiterate this call:

- Development and adoption process needs to be linked to a national structure like the Office of Health Standards Compliance (OHSC) and/ or the National Essential Medicines List Committee (NEMLC) appointed by the Minister of Health.
- Adoption processes must adhere to internationally accepted standards for evidence and consultation. This includes the use of the AGREE standards and domains used by the SA Medical Journal: scope and purpose; stakeholder involvement; rigour of development including evidence; clarity of presentation; applicability; and editorial independence.(15)
- The NEMLC or a non-aligned national structure should align with the AGREE standards with the exception of broad stakeholder involvement and communication. The information and outputs must be accessible in the public domain on a website timeously. Changes must be clearly indicated and if comment is needed then sufficient time allowed. A patient representative on adds to greater transparency and aligns that its recommendations are increasingly patient-centre according the NDP.
- A system for the regular consistent review and updating of evidence-based NCDs standards, guidelines and processes needs clarification, adoption and funding.

The National Health Act and draft regulations place the OHSC as the custodian of national norms and standards with which "all health facilities will comply." (¶ 23, 126, 208, 219-224). While the OHSC took the lead in national core standards development it seems that this is not the case for PHC facilities which is part of the "backbone" of health care and where majority of citizens receive care. The White Paper appears silent on the body responsible for developing PHC facility standards.

The ICRM is developing and monitoring PHC facility standards. (11, 16) It remains of concern that there appear to be no external validity checks and is separate from the OHSC. In research findings presented at the May 2016 Health Systems Trust Conference it appears that reliability is being achieved by repeat measurements, re-education and clarification of standards in the same districts. However, this does not mean that the standards are valid, i.e. that these measure what they are intended to measure or are even important to measure in the first place. It has been argued that this is 'action research.' However, in the absence of external arbitration or citizen input this a moot point. It certainly is not in the spirit of citizen driven accountability and transparency.

All health care standards should have patient involvement at all levels in for social accountability and relevance. This includes the clinical standards for e.g. PC101 (14) that have been included in the ICRM annexures as part of the "package" and are being used as norms and standards.

It is of considerable importance that there is a single clinical standard setting authority within the government domain. The clinical standard setting authority should be separated from the fee structure and NHI Fund.

COMMISSIONS - HEALTH VS NCDs

The White Paper contradicts the current NDoH Annual Performance Plan when noting that the National Health Commission (NHCom) will be established during the first phase of NHI implementation by 2016/17. (¶408-415) We, the citizens, would welcome this development.

To date the NHCom has failed to materialise despite being first recommended by the ANC in 2012 (17), promised in the NCDs Strategic plan 2013-2017 (18) and in successive NDoH plans. (19) It is currently due to resourced and operational in 2019. (20) It has also moved between programmes for in terms of responsibility moving from Programme 4 (PHC) to Programme 2 (NHI) and now appears to be back in the NCDs cluster. (12, 21)

People with NCDs have long been hoping for a NCDs commission as recommended globally to be an independent mechanism and framework for accountability for NCDs action and which includes monitoring and evaluation. Its purpose is to "monitor, review, and remedy areas that need increased attention." (22) This is clearly a different type of body that proposed by the NDoH and is beyond an all-of-government approach to one inclusive of all of society usually meaning civil society and others. The closest example to this is the South African National AIDS Council that received R15 million income (via PEPFAR funding) from the 2014 NDoH budget (23). It includes civil society and all other stakeholders. Its mandate is around policy and the mobilisation of resources HIV/AIDS, TB and STIs.

The World Health Organization realized the need to establish a the GCNMCD mechanism to "enhance coordination of activities, multi-stakeholder engagement and action across sectors in order to contribute to the implementation of the WHO Global NCD Action Plan 2013–2020." (9, 24) The NHCom must deal with NCDs prevention, control and research. If more than one group of illnesses are to be addressed it is suggested that special crosscutting streams for NCDs related-issues are put in place. It is hoped that this body will be openly discussed prior to establishment and that citizens are given a strong and equitable role and support.

In addition, it is recommended that the model extend to provinces since these are the real implementers of health policy. There have been a number of attempts to establish provincial level coordination committees and full support should be given to these with the requisite funding.

It is noted that there is very confusing close terminology: that of the NHCom and the NHI Commission (¶ 421) and the National Health Council of the National Council of Provinces.

REFERENCES

1. Health. Do. National Health Insurance For South Africa: Toward universal health coverage. In: Health, editor. 40 ed. Pretoria2015. p. 97.
2. Pinkney-Atkinson V. Civil society status report 2010 - 2015: mapping South Africa 's response to the epidemic of non-c ommunicable diseases2015:[26 p.]. Available from: https://drive.google.com/open?id=0BwSCBZIT92UoZTJOalRPNTVlUm8.
3. Hall J. Grassroots to global: Seven steps to citizen-driven accountability for the Sustainable Development Goals: World Vision Inernational; 2015. Available from: http://www.wvi.org/sites/default/files/Grassroots%20to%20Global_Report_FINAL.pdf.
4. Hodge J, Fiandeiro F, Lynch S, Mohamed R. Healthcare market background paper2012:[114 p.]. Available from: http://www.compcom.co.za/wp-content/uploads/2014/09/GenesisHealthcare-Market-Background-PaperAug-2012.pdf.
5. van den Heever A. Review of competition in the South African health system. Review. 2012 19 June. Report No.
6. Halse P, Moeketsi N, Mtombeni S, Robb G, Vilakazi T, Wen YF. The role of competition policy in healthcare markets. Competition Commission of South Africa, 2013.
7. Lancet. Universal health coverage post-2015: putting people first. The Lancet. 2014;384:1.
8. National Planning Commission. National Development Plan Vision for 2030. Pretoria: Government Printer; 2011 [cited 2014.
9. Organization WH. Global action plan for the prevention and control of noncommunicable diseases 2013-2020. Geneva: World Health Organization, 2013.
10. Statistics South Africa. Mortality and causes of death in South Africa, 2014: Findings from death notification. Pretoria: Statistics South Africa, 2014 November. Report No.: Contract No.: P0309.3.
11. Health. Do. Ideal Clinic components and definition booklet Version 152015 August [cited 2016 30 May]:[20 p.]. Available from: https://goo.gl/7GCV65.
12. Department of Health. Annual Performance Plan 2015/16-2017/18 draft unsigned. In: Health, editor. draft 7 March ed. Pretoria2015. p. 129.
13. Georgeu D, Colvin C, Lewin S, Fairall L, Bachman M, Uebel K, et al. Implementing nurse-initiated and managed antiretroviral treatment (NIMART) in South Africa: a qualitative process evaluation of the STRETCH trial. Implementation Science [Internet]. 2012; 7:[13 p.]. Available from: http://www.implementationscience.com/content/7/1/66.
14. University of Cape Town Lung Institute. Primary care 101 2013/14. Symptom based approach to the adult in primary care. Health, editor. Pretoria: Department of Health,; 2013. 108 p.
15. Wiseman R, Cohen K, Gray A, Jamaloodien K, Kredo T, Miot J, et al. AGREE to disagree: Critical appraisal and the publication of practice guidelines. S Afr Med J [Internet]. 2014 [cited 2014; 104(5):[345-55 pp.].
16. Steinhobel R, Massyn N, Peer N. The Ideal Clinic Programme 2015/20162015:[99 p.]. Available from: http://www.hst.org.za/sites/default/files/Ideal_Clinic_Programme_WEB20Oct2015.pdf.
17. "African National Congress, editor 53rd National Conference Resolutions African National Congress National Confress; 2012 16-20 December, 2012; Mangaung, .
18. Health Do. Strategic plan for the prevention and control of non-communicable diseases 2013-17. Pretoria: Department of Health, 2013 RP06/2013.
19. Department of Health. Annual performance plan 2013/14 - 2015/16. In: NDoH, editor. 2013. p. 140.
20. Department of Health. Annual Performance Plan 2016/2017-2018/2019 2016.
21. Health Do. Annual Report 2014/15. Pretoria: 2015 October. Report No.
22. Beaglehole R, Bonita R, Horton R. Independent global accountability for NCDs. The Lancet [Internet]. 2013; 381(9867):[602-5 pp.].
23. "Department of National Treasury. Budget 2014 Estimates of nationa expiditure. Vote 16 Health. In: Treasury N, editor. 2014. p. 64.
24. Organization WH. Global Coordination Mechanism for NCDs 2014 [cited 2014 20 Nov]. Available from: http://www.who.int/ncds/gcm/en/.