Young People's Recommendations on South Africa's NHI White Paper.

The following is the Young People's Recommendations on South Africa's NHI White Paper. 2016.

Coordinated and facilitated by People's Health Movement-South Africa (PHM-SA): Version 2-29 July 2016.

i. Background

The United Nations (UN) Sustainable Development Goal (SDG) 3 calls for member countries to commit to 'ensure healthy lives and promote well-being for all at all ages' (UN 2016). Target 3.8 specifically calls for the achievement of Universal Health Coverage (UHC), including financial risk protection, access to quality essential healthcare services and access to safe, effective, quality and affordable essential medicines and vaccines for all.

We believe that UHC is a powerful concept and component in public health, which contributes to citizen welfare, social solidarity and security, and are in support of a NHI, with a few limitations. Health reforms were put on the agenda in South Africa (SA) as early as 1921. In the 1940's, Sydney and Emily Kark (Against The Odds 2016), and Edward and Amelia Jali (Kautzkyi and Tollman, 2008) with the support of the then Health Minister, Henry Gluckman, who set up the Gluckman Commission which aimed to develop a National Health Service (NHS), funded through taxation, and available to 'all people in SA according to their needs and not according to their means". These plans were shut down by the Apartheid Government (SAHR 2008: pg. 19).

Young people applaud the African National Congress (ANC) for placing health reform on the agenda in 1994. We acknowledge the progress made in the 'White Paper on the transformation of the Health System', the free access to Primary Health Care (PHC) services by mothers and children of our country.

However, it was only at the party's elective conference, fifteen years later in 2009, that a firm commitment to implementing UHC was made by the SA Government, the National Department of Health (NDoH) and the ANC, driven by the National Education Health and Allied Workers Union (NEHAWU) and its Secretary, the SA Communist Party (SACP).

Two years later, in August 2011, the release of the Green Paper proved a promising step forward, however, it is the release of the NHI White Paper that SA citizens have anticipated. Released on 10 December 2015, this long awaited policy paper carries the hopes for a South African version of UHC: a foundation for SA's plans to realise the rights of South Africans as enshrined in Section 27 of our Constitution, and as stipulated in the National Development Plan (SAHR 2008: pg.19).

ii. Introduction: Our Position

Young People's responses to the NHI are crucial because the decisions made will affect us directly. The NHI offers citizens the opportunity to contribute towards a more equitable health care delivery system. As future beneficiaries and contributors to the NHI fund, we want to be part of this process, We want to understand the NHI plans, and have our voices and concerns taken seriously.

This document presents a multi-sectoral youth perspective on the NHI White Paper, which takes into account young people's experiences and knowledge of public health care clinics and hospitals. We come from Universities across the country: academics and activists based at the University of Pretoria, University of Cape Town, Witwatersrand and government facilities, and have collaborated on a number of platforms to formulate this response. This includes; attending meetings, workshops, discussions on social media, and web-based platforms.

Young People welcome an NHI, welcome engagement for input, and want to contribute to an NHI which addresses current systemic issues and truly meets SA's needs. The NHI might not address all challenges in both the private and public sector, but the SA government is certainly on the right path to doing so. This document spells out a summary of the discussions held, input provided by youth, which should be taken into consideration, as SA moves towards implementation of the NHI. Moreover, we the young people of SA call for the timely and effective implementation of NHI.

iii. Methodology

We pooled our resources, networked, and engaged honestly with each other about our goals to formulate this response. We established a baseline of trust and understanding that the NHI would impact us all. It would be our responsibility to ensure that we made our voices heard about the pitfalls of the NHI that related to each of us.

We used social media i.e. Facebook and WhatsApp. We used email and Google Shared Documents to document our responses.

1. Public Health System, Structural Challenges

Fragmentation

Fragmentation of the health system is evident in the complex management and leadership challenges; poor quality of care regardless of cost in the private and public sector, the 000000 resource (HR) crisis, most notably, the poor task shifting, and maldistribution of HR across the country, and the fragmentation within the health system and poor linkage and data management of how socially determined factors impact on health outcomes (SAHR 2016: pg.4) (Rispel2016).

Given that NHI is a financing system designed to pool funds to provide access to quality, affordable health, based on need, our primary concern is with the numerous structural challenges with the current health care provision system, or non-system. The fragmentation of the health system cannot be overlooked in the change process.

The NHI proposes changes to an already fragmented system (or non-system) described above, without considering the readiness of the system to deal and cope with the changes (Rispel 2016).

System Readiness

Literature on system readiness must be studied and unpacked, taking into account all the necessary steps to achieve success. This will inform the phasing, timing, sequence and steps in the reform process.

System readiness could include inter-sectoral engagement with the diversity within national ministries, as well as the SA population across gender, race, age, income, class, and other lines.

Infrastructure

While the NHI White Paper states that 'users of the public health system would be expected to visit their closest clinic or hospital and there will be a clear referral system', this assumes that specialist services are provided in the area (and at the closest health facility); otherwise, people will still have to travel. It would be unfair to restrict individuals from accessing a clinic that they feel will serve them better. Furthermore, being restricted to a facility in their area that is not up-to-standard, as many clinics are not meeting the standards required.

For people to visit their closest health facility, they will have to be satisfied with the services provided by this facility and the attitudes of staff at that facility. This means that the health facilities should be improved: structurally to include adequate sanitation, electricity, and a proper road to the health facility.

The facility will need to have the required and necessary equipment which is maintained, functions adequately, and has the necessary medication which is not out of stock. Patients can't be expected to attend a health facility where they do not feel welcome, or do not receive the quality of services that is needed. Patients attending health facilities are unwell, and should be supported and treated with dignity and respect.

All public health clinics must be of quality, to enable the use of local clinic facilities. If this is not the case, users will continue to use hospitals or private health care facilities, once again, adding to inequity.

In the future, communication should be made with Presidents of the different nations, to subsidise the country for the services rendered to foreigners occupying SA legally or illegally.

Questions:

1. How does the system propose to deal with the challenges that the old fragmented system faced?

2. How will asylum seekers, refugees and economic migrants, especially the unregistered ones, be considered and cared for by the NHI beyond just accessing emergency services?

3. Has system readiness and fragmentation thoroughly been considered?

4. Will more money be invested in refurbishing and developing public facilities to a standard of quality that is assessed by an independent contractor?

2. Leadership and Governance

As young South Africans, we need our leaders to make decisions that ensure that we get the 'best bang for our buck', through cost-effective spending, better management of resources, and investing in primary care services that are responsive to the community.

The SA government needs to seriously and urgently tackle the culture of corruption that pervades our society (Rispel 2016). As young people, we need government to detail how it plans to build a structure that builds in a rigorous accountability framework. Without transparent accountability there will be no trust.

A better working environment for young people will influence us and the workforce in general to stay in SA. The PHC model relies on health personnel working closely together; for example: Audiologists working well with Medical Doctors – these relationships need to be fostered at health science campuses.

As young public health practitioners, we expect our leadership to show a firm commitment to placing the SDH at the top of SA's agenda. We believe that the success of NHI will be determined by the holistic, integrated and comprehensiveness of the approach to address health inequity. For example, the education of the girl child initiative has proven to have a positive impact on the life of the young woman, her future decisions around family planning and employment.

Identifying the SDH is simply not enough. We expect to see the involvement of other Ministries, much more deliberate engagement, policy development, and well-designed implementation strategies. A good example is the Operation Sukhuma Sakhe approach in Kwa Zulu Natal.

Young people are pleased to see that the Primary Health Care re-engineering model was designed to focus on the district health system (DHS) in the delivery of health care services in an effort to decentralise services. However, we are concerned about the existence and capacity of the DHS to manage and lead these functions.

Governance

Involvement of other Ministries in addressing social determinants of health such as the education department plays the most important role in providing the groundwork for the health sector. Educated individuals will have a higher chance of making informed decisions regarding their health.

Questions:

1. How will you appoint effective, honest leaders to occupy positions of power at municipal, district, provincial and national level? What are the lines of authority, referral, and accountability systems going to look like?

3. Engagement with all Sectors of Society

a. Citizens on the ground

Engaging citizens on the ground is a challenging task, given the extent of income inequalities! To this point, the drivers of the NHI have adopted an authoritative top-down approach rather than a comprehensive combination integrated approach to mandates and policies around implementation.

b. Middle Class and Elite

The approach to integrate the NHI into society should ensure that those in power, the middle class and the elite, are engaged to the point that they can begin to understand and accept their responsibility to redistribute their resources to the poor, with a vision that this is part of the process of realising the right to health as enshrined in the Constitution of SA.

The NHI presents an opportunity and can be a tool for politically uniting the South African population, within a vision that actively seeks to realise the ideals written in the Constitution.

c. Multi sectoral Engagement

The link between health status and the social determinants of health are evident (Bradshaw 2008), which points to the necessity to engage stakeholders in multiple sectors, to integrate the Health in All Policy approach (HiAP) (PHASA 2013).

Government must involve community members in decision making. Those community members must hold government accountable. Community members and representatives should sit on the National Board to limit corruption-preferably educated members.

While there are numerous academic resources available on the NHI, it is a sad fact that health care workers and citizens of SA remain uneducated and unfamiliar with the NHI plans. We demand that greater efforts be made to engage across all sectors of society. Details of this plan must be provided. This must include countrywide communications campaigns and popular education.

There is a tendency to take a paternalistic approach when dealing with the poor and the disenfranchised in SA. This is reflected in the attitude of shifting the responsibility of health care from the state to patients: blaming the sick for their conditions; for non-adherence to treatment; for delaying health seeking behaviour until the need for curative care becomes necessary. There is a large gap between the policy maker's rationality versus the people on the ground's rationality and understanding. This disjuncture creates a huge gap, contributes to the inequity and silences the poor. Until meaningful community participation becomes central to the NHI agenda, this challenge will perpetuate and the NHI will not be accepted by the people of SA.

Policy makers must become more sensitive to the challenges, fears, and stigma-related concerns of the citizens that the paternalism reinforces.

Campaigns in low and no income areas could be employed to build trust in public health facilities, so that once the NHI is fully implemented, no income and low income citizens consider public health clinics as trusted service providers, which in turn would lessen the burden on public health hospitals. This must be done in tandem or after ensuring that infrastructure deficits are addressed.

Government could consider engaging certain populations thoroughly with cell phone and web-based applications similar to those offered by the Open Government Foundation. The NDoH could work with organisations such as Code4SouthAfrica to better engage specific citizen populations. Consider ways to elicit input from citizens on the ground, using SMS's although already being done but it needs to be taken to scale.

Questions:

1. As a young person, studying public health, how will I be included in this process more effectively?

2. How will the poor, sick, hungry and disenfranchised of our country, the people in 'people's health systems', be engaged and involved so that their voices are heard in these plans that impact them the most?

3. How will medical anthropologists, sociologists, economists, town planners, architects and IT specialists be included in these discussions?

4. How will researchers be able to enable and facilitate all of the above mentioned processes?

5. How is inter-sectoral work going to support the NHI through a ''health in all policy" (HiAP) plan? Policies and specialists don't adequately speak to each other now, how will this be addressed?

6. How will street level bureaucrats who pose barriers to care, be engaged?

7. How will traditional healers and herbalists who represent different health belief models across all sectors be engaged?

8. Given that disposable income of the elite will be reduced for a long period without seeing or reaping the benefit of the tax pay out, has the NDoH considered how to engage the middle class and the elite?

9. How do you plan to build trust across all aspects of SA society?

4. Primary Healthcare (PHC) at the heart of NHI

PHC should be at the heart of the NHI and should be based on the principles of equity, and social justice, inherent in the Alma Ata Declaration (WHO 1978), and the 2005 Commission for SDH (CSDH) (WHO 2016).

SA needs to accelerate the overhaul from curative care towards a primary care approach. Care should be taken that the NHI does not end up being an entrenchment of the predominantly curative model currently in the private sector. This must be evident in the budget allocation to primary care, so that a conditional grant is set up for PHC services. This involves preparatory work to ensure the PHC system can cater to the SA population through the provision of quality PHC services.

The emphasis on the PHC approach should reflect the HR4H plans, where primary health care nurses, family physicians, clinical associates, community health workers and allied health workers have an instrumental role to play. Without the correct set of front line workers, with the correct skills, a PHC approach is not possible.

If GP contracting is part of the NHI strategy, the SA government must change the medical curriculum, to ensure that all front line providers are trained to address population health outcomes.

Front line providers must be socially accountable citizens who are passionate and conscientised towards servicing their population. This must reflect in the incentive strategies, both financial and non-financial for specialisation and career development within the PHC sector.

The hierarchy and emphasis on super-specialisation in fields such as cardiology, dermatology, surgery is counterproductive. While these services are essential to the health system, there must be a balance and shift in approach to ensure that PHC becomes a viable career path for all healthcare professionals across SA.

Given SA's high GDP spend in health, it is a travesty that South Africans continue to die without receiving the available care (Death and Dying Report 2013). This is a complex issue, with both demand and supply side barriers to care.

Until the PHC clinics are functioning at an optimal level, and the SA population develop trust that they will receive quality services from the PHC level, they will not follow the proper referral channels and will continue to bypass the PHC and DHS, going straight to tertiary hospitals.

More support should be given to health facilities. Often, policies are changed or updated, and is only communicated down to facilities. The health facilities are not supported as they should be for the implementation of the new, or changed, policy. Clear standard operating procedures (SOP's) should be given to health facilities, and the health care workers should be adequately trained on it.

Operating times of the PHC's should be reviewed. The working population are often unable to attend a PHC for their healthcare needs, and end up going to a hospital. This has an impact on the "outpatient referral rate" indicator.

Questions:

1. As young people, we recognise that PHC should be at the 'heart of the NHI' and that it should be

comprehensive and integrated, but some young people are also concerned about the move towards

PHC: What about young people who wish to specialise, and find that there is no room for specialising in a system that primarily focuses on preventative approaches?

2. Will the NDoH be able to implement such a system where the PHC could be at the heart of the NHI?

3. How much funds are allocated to PHC to ensure that this happens?

4. We are deeply concerned about how this process will be implemented, and by whom?

5. Primary Healthcare Reenigineering

As young South Africans, we agree the reengineering of Primary health care must occur in a way that places emphasis on a population-orientation to health care, and takes into account the priority health

needs of a defined population. We agree that services must be delivered in a comprehensive manner, focussing on improving health outcomes; and reducing mortality and morbidity levels.

We recognise that the PHC strategy aims to pay closer attention to: 'upstream factors', the social determinants of health; quality of care though improved clinical governance and supervision at a district level, strengthening community participation and inter-sectoral collaboration, district management planning, budgeting and implementation and strengthening district hospitals.

We agree with the plans to create an innovative team based approach that is integrated, well supported, and guided by, and accountable to communities served. The team work may prove effective in mobilizing the community; delivering health promotion and prevention and prioritising maternal and child health, HIV and TB care. We will comment on each of the four streams of PHC reengineering: district-based clinical specialist teams (DCSTs); ward-based primary health care outreach teams for each electoral ward (WBOTs); Municipal Integrated School Health Programme (ISHP); and General Practitioner (GP) Contracting (NHI White Paper 2015: pg.2).

6. Human Resources for Health (HRH4H)

At present, moratoriums on hiring staff – also known as hiring freezes – (PHM-SA 2016), in already shortstaffed public health clinics and hospitals, seem congruent with budgets running low, but incongruent with the implementation of an NHI, which requires additional human resources for it to run efficiently. There is no congruence between the HRH policy and the NHI, and the NHI document does not outline who must carry out the roles described.

Government will not be able to prevent brain drain by forcing any member of the health workforce to stay in SA against their will (Elliott 2016). It cannot be expected of a healthcare worker to work in a facility without the needed resources, and where they are over-worked, under stress and often times in danger.

We will need to improve our health system, if we want to retain our workforce.

a. Graduates

One of the reasons why South Africa is "leaking" healthcare professionals is healthcare professionals especially nurses are underpaid. Another reason is that the qualification process is too exhausting. As a pharmacist, one studies for a 4-year degree then a one-year internship followed by a year of community service (CS).

Internship is essential. CS on the other hand needs reviewing. Although CS is meant to service underserviced areas, that is not the case. These underserviced areas usually do not have the budget

to accommodate a Community Service Pharmacist (CSP) and this results in pharmacy interns waiting for long periods of time (six months to three years after completing internship) to get placed, especially if they're foreign. Ideally, upon completing an internship in December, the interns should be placed such that they start working as a CSP in January of the following year. This process is facilitated by the NDoH which is responsible for placing interns at various government institutions. What is surprising is, although there is a shortage of healthcare professionals, for example, pharmacists, they are struggling to get placed as CSPs.

In some cases you find that hospitals will have available posts for CSPs but when the intern enquires with the NDoH they are told the opposite. This could mean there's a communication gap or flaw of some sort in the system. Either someone somewhere in the system is not pulling their weight or there's something being overlooked. Clearly there is some form of communication breakdown as the database of the NDoH tells them that a particular post is filled when it is not, or when the NDoH database says the post is available when it is not. By here say, this sometimes happens when an intern is accepted at, say three hospitals and they choose one of them, and instead of informing the other two hospitals that they have been placed at another hospital and will therefore not be filling that position, they do not respond and the two hospitals assume that the intern is yet to come to their hospital, which is not the case.

The post-study period for one to be considered a "qualified pharmacist", for example can be exhausting. The issue here is, for one to be titled a qualified pharmacist in South Africa one has to do community service, which is very necessary. The issue is now with pharmacy interns having to wait up to three years just to be placed for CS. CS can only be done in government hospitals or institutions, which is fair as they are the most underserviced. If only placement was better managed. One can only wait for placement by the government itself. Imagine an intern being unemployed for three years. Where are they staying? What are they eating? Is it really necessary for that to happen? After all, their services are required. Why not use them? In other countries, after qualifying for a pharmacy degree one might undergo one-year internship, after which one becomes a pharmacist.

To elaborate on the CSP placement issues;

Example 1: An intern applies for CSP placement. They get placed but the hospital claims there is no post.

That intern then does a back and forth between the hospital NDoH to try confirm placement which can take months. If lucky, the issue is resolved in a couple of months to a year. If not so lucky, the intern starts afresh with the application process.

Example 2: An intern applies and does not get a response at all. They keep applying and making phone calls without any luck. After making phone calls, intern finds out all the posts at the places they were hoping to be placed at are filled. The intern is placed on the waiting list (sometimes not) and is eventually advised to apply the following year since there are no posts available across the country for that year. If lucky, the intern gets placed the following year. If not, the cycle continues until they are eventually placed.

One solution to this predicament would be to cut out the community service and have interns choose where they want to work after internship. This allows employers and interns to choose their employee or employer when needed, more like cutting out the middle man (NDoH placement). Having done that there would be need for incentives to attract them to underserviced rural areas with transport allowance, and accommodation, etc. Another need would be to provide the underserviced areas with enough resources (especially funding) in order for them to afford a CSP as some do not even have pharmacists at their exposure.

Community service is indeed a very necessary procedure as it is 'a rigorous process that develops a more robust and resilient health care professional' the way in which it is currently managed does not seem to be benefitting the community at all, and the healthcare professionals involved as some of those healthcare professionals are not afforded the opportunity to carry it out, or in some cases, if they eventually are, by the time they get placed all they want now is to qualify and leave. The exhausting procedure of having to wait for a very long time to be placed may perhaps influence them to not want to work in an environment where it takes a very long time to get things done, hence after community service they move to the private sector where things are done proficiently and efficiently.

Although CS 'embeds social responsibility', if only all these graduates could be placed and be afforded the opportunity to actually get into the system as health care professionals, if only placement was better managed. Over the years "potential pharmacists" turn to academics. Does South Africa need more pharmacists or academics? We need more staff serving patients but at this point and at this rate there'll forever be a "shortage" of health care professionals. Some "potential pharmacists" have turned to other countries due to all these CSP placement issues, again South Africa bleeding the healthcare professionals it requires.

This placement issue might just be a governance issue. One applies through NDoH & placement is issued by NDoH. Of course there are other factors that may influence the placement e.g. availability of CSP posts at hospitals (which in some cases are thought to ultimately be controlled by NDoH since they are government hospitals), where NDoH liaises with the various hospitals' management and HR departments.

The “government employee (civil servant) culture” where-in people believe that just because they are working for the government they are entitled to do a “mediocre job” or provide “mediocre service” should be discouraged and disabled. It could be one of the reasons that the whole placement issue exists.

Some say new graduates are not being placed in community service or first year registrar posts, because the posts have been cut due to budget shortages (Health-e 2016). When existing facility staff are expected to absorb tasks, it leads to a disgruntled and overworked workforce, which continues to lead to high staff turnover and attrition. Most young people pay for their own studies, so it’s not recommended that young people or any professional are told where to work, after they have already worked so hard to pay for their studies themselves.

b. District Clinical Specialist Teams

To produce an NHI compatible health professional, medical schools can be standardised for the NHI, but this alone will not influence the kind of doctor who will enter our society.

Unfortunately, this is a personal factor alone and only the doctors themselves will be able to take what they can from their time spent in medical school, and choose what footprint they will leave behind.

A better working environment for young people will influence young people and the workforce in general to stay in SA. Most young people pay for their own studies, so it’s not recommended that young people or any professional where to work after they already worked so hard to pay for their studies themselves.

We are aware that there are four streams for PHC re-engineering: Municipal Integrated School Health Programme (ISHP); District Clinical Specialist Teams (DCSTs); and contracting of non-specialist Health Professionals. (NHI White Paper 2015: pg.2), for the time being, we place emphasis on three which pose challenges.

The DCST initiative aims to recruit specialists to the local level, to avoid unnecessary referrals and provide a more comprehensive range of local-level services. In urban areas most of the DCST posts have been filled.

However, in the rural areas like Mpumalanga and the Eastern Cape, there have been challenges in filling these posts.

There is uncertainty of their exact role and how they fit into the existing health care system. This would be an ideal addition to the system, but the conditions under which these specialists and even health

care practitioners have to work, are dire. It's no wonder that some posts aren't filled, because the working environment and equipment needed to do so, fails them.

c. Community Health Workers (CHW)

Young people believe that the Ward Based Primary Health Care Outreach Teams (WBOT) is a step forward towards achieving comprehensive integrated primary health care, with the spirit of social justice. Literature shows that CHW's are a feasible task shifting strategy to address the HRH crisis in health care.

Furthermore, CHW's are an essential bridge linking poor communities with the health facility, through community agents or members in a specific community. However, the WBOT program faces many conceptual, HR and implementation challenges that could threaten its survival and uptake. Conceptually, the program has an inconsistency in its embeddedness into the PHC system. A decision must be taken to determine if CHW's will be formally incorporated into the hierarchy of the health care system, if they will receive an NQF qualification for their training and if there is a career path for them to follow. Employment contracts must be drawn up to support their right to work for a living wage. An amount of between R1200-R2200 is unacceptable. They must be entitled to sick leave, UIF and representation with a union.

Despite the fact that CHW's come from the communities they serve, the entire program needs to be accepted and valued by this community. This means that the community must understand the program in its entirety, and must participate in adapting its design to suit the local context.

CHW's collect extensive data that must be recognised and incorporated into the health system database.

This data must be captured in such a way that its validity can be checked, the quality of the data maintains a high standard, and there are accountability mechanisms in place. This could be electronically or paperbased, however it is unacceptable for CHW data to be lying in boxes for months.

CHW's must have a sense of belonging in the health facility. They must be accommodated, by giving them appropriate work space and storage space. They must be given uniforms and name badges in order to have a professional appearance. They must have the daily resources they require to provide promotive and preventative care.

The scope of practice of CHW's must be considered. The inclusion of basic curative care and delivery of medication are essential to ensure greater cost-effectiveness of such an investment in CHW's. Regular ongoing training at regular intervals, with supportive supervision is essential to quality service

provision. A manageable workload and travel distance must be considered; to ensure they feel motivated to continue their work.

CHW's face trying conditions such as having to walk long distances to access households, facing safety and health risks. Additionally, they face challenges of the sick, diseased, abused and elderly. Their well-being must be central to the program, with provisions and debriefing, emotional support, transport and security where necessary. It is crucial that these issues be addressed to ensure the sustainability of the CHW model.

d. Ward Based Primary Healthcare Outreach Teams (WBOTs)

Conditional budget allocation with accountable spending on the WBOT program must be ensured, through a process of outcome evaluation.

Embed WBOTs into the PHC system through record keeping, management of referrals, ongoing training, supportive supervision, and nurturing a supportive environment. Meaningful community participation must be nurtured.

e. Private GP Contracting

Contracting of private providers has been moved to the second phase of the NHI implementation process (2017/18 to 2019/21). However, this component of the NHI continues to be a problem, so much so that contracting of private providers has been listed as a fourth stream of PHC re-engineering, under the White Paper, though no fixed deadline has been set to contract staff over the next implementation phases (Choonara & Eyles, 2016).

A cost-effectiveness analysis exercise must be carried out to show how many Disability Life Years (DALY's) and Quality-Adjusted Life Years (QALY's) will be averted, through implementation of the WBOT program.

This should inform the budget allocation and investment into this program. Currently the University of the Western Cape (UWC) is offering training for Community Health Workers to equip them for service. More of such initiatives should be implemented and supported to formalise the training and enrolment of CHW's.

To increase the number of health science students enrolled at medical schools to feed into the need to increase the health workforce with NHI implementation, consideration needs to be made to increase the amount of bursary funding available to assist capable students, who just need financial support.

Questions:

1. How does the NHI ease the burden of the workforce and encourage them to provide better quality health care that improves access and removes barriers?

2. What about those specialists who have been trained for skills that fall outside the list of services covered by the NHI fund?

3. What incentive structures are going to be used to keep health workers motivated?

4. Has the NDoH considered how this contributes to brain drain?

5. How does the NDoH aim to address brain drain?

7. Service Delivery

The public sector in SA is poorly managed, characterised by poor quality, extremely long waiting times, inefficient referral systems, unclean facilities and frequent drug stock-outs.

Questions:

1. The preventative and curative administrative burden to manage finances is a huge concern. Has the readiness of the health system been considered?

2. And will those responsible for these administrative tasks be given the necessary equipment i.e. computers, high speed internet, availability of necessary resources?

3. Moving forward, what of space for local innovation to fit specific contexts and respond to health needs of patients, instead of meeting demands of DoH?

8. Cost Considerations

The cost for the NHI is estimated at R 225 Billion rand (Eyles 2016). In May 2016, Dr Aaron Motsoaledi states, “There isn’t a pot of gold for the NHI. It requires reorganising money that is already there,”

Motsoaledi said this to Health-e News. He added that employers got around R16-billion in tax incentives for staff medical aid subsidies, while medical schemes had around R43-billion in reserves (Health-e 2016).’ Key stakeholders indicate that there are no extra funds available for the NHI, while the poorly equipped public health system slogs on with a quadruple Burden of Disease (BoD), Non-Communicable Diseases (NCDs) and mental health issues on its back the lack of funds is a hazy issue, which needs more exploration, and deeper investigation.

In March 2016, Motsoaledi states, “We do not envisage burning medical aids en masse,” in an interview with the Financial Mail. “We don’t think it will be fair to say that private schemes like Discovery are no longer going to work. We want people to make their own choice. We want to make

it clear that NHI will be mandatory, just like it is in England (Financial Mail 2016). No millionaire is not part of the (UK) National Health Service but if he wants to do something privately, it's allowed." This indicates that tax payers could be contributing twice to health services.

The high costs associated with health care, medication, labs, consumables, and the wastage of financial resources and consumables are problematic. The expenses associated with prioritising curative care over meaningful community participation, proactive health promotion and early detection of illness, and disability prevention is higher. 'Capital spent on prevention strategies and implementation might be high initially, but in the long run will drastically lower overall costs, pertaining to our current system, 'The NHI should 'aim to reduce delivery fragmentation, pool risk, enhance life expectancy, increase labour productivity and household disposable income, contribute to macro-economic growth' (Eyles 2016: s. 1-38)

a. The Ideology of Cost: A Socialist Policy in a neoliberal environment

The NHI White Paper takes a socialist approach to universal health care in a neoliberal environment. Support from key stakeholders, including citizens and doctors, is necessary, as is decentralisation and proper funding. Yet, significant questions remain. As noted in parliament, the NHI is a largely socialist, solidarity initiative which will be difficult to implement in SA's neoliberal Environment, which makes provision for profit sectors and consumer choice (Choonara & Eyles, 2016). Some young people are concerned for SA's economic wellbeing.

b. Cost to Taxpayer

The White Paper rightly acknowledges that state contributions to medical aid schemes (R20-billion) should be redirected and that regulation of the private sector will also assist, with raising and redirecting funds towards NHI (Choonara & Eyles 2015).

There are already high levels of dissatisfaction amongst citizens around increased taxes and having to pay for public health care, which many consider highly inadequate and of poor quality (Choonara & Eyles, 2016). In Gauteng we aren't going to struggle only when it comes to the payment of taxes but the E-toll system as well. Then there's the consideration about profit over people's health (ENCA 2016).

c. Cost to Public Health User

The White Paper implies that if public health users fail to follow the referral system or use peripheral facilities, they may be charged more if they travel out of their area or skip referral lines. In such cases, the NHI will still pose an indirect cost to public health users while perpetuating out of pocket

payments. In addition, some clinics are of such poor quality (NSP Review 2015) that it is inevitable that users will go to facilities outside of their locale.

At present, our public facilities work on an honesty policy. This can be easily bypassed and one can get away with using public resources while you can afford a medical aid and private facilities.

The cost, coverage aspect is encouraging: user-fees will be abolished, and that out of pocket payments at the point of health care delivery, is not expected.

We recommend that 'services provided will be paid for through the NHI Fund that 'NHI card holders will not be expected to make any out-of-pocket payments such as co-payments and user fees at the point of health care delivery' in an effort to prevent demands for informal payments or the practice of 'balance-billing' by providers (Eyles 2016).

Abolition of universal patient fee – no fees will be levied at public sector hospitals, except to non-citizens, third-party payers such as medical schemes, Road Accident Fund and Compensation for Occupational Injuries and Diseases.

d. Reliance on the Private Sector

SA needs to guard against an over reliance on the private sector: while they might be most capable of managing the funds, their primary concern is to increase profit – which is contrary to the goals of a universal coverage scheme. Public Private Enterprises(PPE's) must be avoided. Administering the costs of the NHI fund will be a costly exercise and these specifics need to be outlined transparently.

e. Private Healthcare Providers

It is not clear how private providers will be contracted and the role of medical schemes at this stage is set to be complementary to the national fund, though details around this remain unclear.

f. Private Sector Regulation

The NHI Green Paper argues that over the past decade private hospital costs have increased by 121%, specialist costs have increased by 120% and member contributions to medical aid schemes have doubled over a seven-year period, pointing to the fact that the private medical insurance is pricing itself out of the market and contributing to further inequity between the public and private health sector (Choonara & Eyles, 2016). Even though it has been stated in the Green Paper, pricing in the private sector in itself did not solely account for the iniquitous gap between the private and public health sector. While pricing remains a large contributing factor, it is a multifactorial issue where inadequate distribution of resources, funding and many more factors are at play. Detail is lacking on the regulation of the private sector and its future role.

Questions:

1. Would it be worth considering a policy trajectory that's based on the clear objective of entrenching income and risk cross-subsidisation mechanisms that will ensure that all citizens are provided with (1) adequate financial risk protection; (2) an opportunity to equitably benefit from the health system; and (3) the ability to contribute towards the funding of the health system based on their ability to pay?

2. How will the NHI cover the fact of actually viewing all the patients as they are in their own situation, rather than again subdividing them into race, financial status?

3. If tax payers pay for health services twice, how will we engage with the frustration of the tax payer?

4. The NHI White Paper takes a socialist approach to universal health care – how will it be implemented in SA's neoliberal environment?

5. The proposed NHI essentially would nationalise the health system. Would this be the most cost effective way of delivering quality and affordable health service to the public?

6. How will public health medical specialists, health economists, public health managers, implementation science experts, and other financial expertise be included in the planning and management of these functions?

7. Giving services free without supplementing the system creates backlogs in labs and contributes to drug stock-out challenges. Have we learned the lessons from the past, which taught us that making services free without supplementing the system with human resources, resulted in unwanted high staff attrition rates?

8. How is corruption going to be prevented at this level?

9. Decentralisation, Supply Chain, Procurement

Key elements, such as decentralisation and improvement of support functions, financial management and procurement, remain poorly articulated.

The Department of Health (DoH) presentations to Treasury indicate that challenges in most of the pilot districts are linked to supply-chain hurdles and delays in procuring items, the inability of districts to use and access financial resources, the inability to spend on infrastructure and the lack of support from provinces.

Both the Green (2011) and White Papers (2015) emphasise improvements in supply-chain and financial management, however there is inadequate attention paid to how these issues will be

resolved moving forward. Insufficient decentralisation (delegation of authority) to the district level continues to hinder districts from accessing and using financial resources (Choonara & Eyles, 2016).

Regarding the procurement of medications, the White Paper proposes a centralised procurement system and creating a purchaser/provider split to procure health services, as possible solutions. Yet current provincial centralisation for HR and infrastructure spending has not greatly improved service delivery.

Many studies illustrate that current delays in procurement are already linked to the ongoing centralisation of important functions at the provincial level. It is also unclear yet how the intended purchaser/provider split will enable efficient use of resources, better accountability and fit into existing health systems – creating a purchasing function at the district level, already challenged by insufficient managerial skills, may add further complexity instead of achieving efficiency.

Decentralisation by making the district health system the institutional delivery vehicle to achieve robust comprehensive and responsive PHC system, is a good idea.

Questions:

1. How will procurement be decentralised and should it be centralised?

10. Basket of Services and Prescribed Minimum Benefits

The White Paper remains contradictory about the basket of services to be offered, stating on the one hand that the "NHI will provide a comprehensive package of personal health services", but also that priority setting and progressive realisation will characterise that process: "NHI will not cover everything for everyone". Please state clearly the limitations of services that are to be offered, as this only confuses citizens and implants expectations that may not be met.

Questions:

1. How will the basket of services be determined?

11. Technologies

SA's eHealth strategy acknowledges that leadership (political, executive and clinical) is necessary to implement eHealth interventions and initiatives (eHealth Strategy 2016).

The strategy realises that effective collaboration with all stakeholder groups are necessary to integrate eHealth such as telemedicine and mHealth technologies. Consultation with public health users on this matter seems lacking. There are privacy risks that users need to be made aware of.

In 2014, interoperability of eHealth technologies, addressing the exchange of data from local to national, from municipal to national level, was still a huge concern (CSIR and DoH 2013). The unique patient identifier was also a concern (Chowles 2014). While the private sector is considering how to tap into SA Treasury's national health budget by framing eHealth as an infrastructure line item, public health facilities fall to pieces in the Eastern Cape (NSP 2015).

While we are aware that open source software poses a problem for interoperability, perhaps SA should consider having software designed that it owns, that can be applied across the board.

Broadband speeds have been touted as an issue with connection issues being a concern in rural areas (SA eHealth Strategy 2012) (Harker2014).

While the value in technology is evident, hasty transitioning could be riskier. Albeit useful, change management still delivers slow progress in bridging the capacity gap (SA eHealth Strategy 2012).

Unless we're employing the services of the most experienced eHealth specialists in the world, 'eHealth competency framework for health workers' will also be delayed. Thought needs to be put into how government can employ and afford these specialists (SA eHealth Strategy 2012).

As it is, in certain metropolitan areas where free Wi-Fi is offered, connectivity is non-existent (SA eHealth Strategy 2012).

While all these technologies: medical record systems, healthcare information systems, surveillance systems, business intelligence for health, electronic content management, decision support and knowledge management, will no doubt add and support human efficiency, if not approached by government efficiently, from baseline, they will also lead to surveillance that could infringe privacy or worsen the current state of public health facilities (SA eHealth Strategy 2012).

While young people are by no means technophobes, they are aware that if prudence is not applied to how we approach the procurement, integration and implementation of technology, human rights could be taken advantage of, (SA eHealth Strategy 2012).

By the same token, while preparing for the implementation of the NHI, current surveillance systems need to be evaluated and upgraded. We rely on surveillance systems for all of our health data, and system indicators. Surveillance systems that needs to be evaluated, include: ETR.net, EDR.net and the National Disease Surveillance Systems.

12. NHI Card

Identification is already a challenge. A number of our patients do not have an identity document (ID), and do not know their ID number. Using the ID number would not be adequate for creating a unique

number for the NHI card. Rolling out of the NHI card needs to be done efficiently. This can be done through using Post Offices or a widely available franchise. This will bypass current administrative insufficiencies of Home Affairs. In deep rural areas, one can consider a mobile office to travel out to the most vulnerable groups to issue them with cards.

Questions:

1. Have we thoroughly considered the digital divide in rural areas?

2. Young people would like to know if strategic priorities set in the eHealth Strategy 2012-2017 have been adequately met to support the requirements of the NHI?

3. Have we solved spectrum issues (eHealth Strategy 2012)?

4. How does the NDoH plan to engage with all stakeholders meaningfully for effective integration?

5. Have the privacy risks been considered and have citizens been consulted about third party appropriation of personal information?

6. Have interoperability standards been agreed on?

7. Have citizens been consulted throughout the design and conceptualisations of the unique patient identifier and central data base designs?

8. Have the broadband issues in rural areas been addressed?

9. Have procurement standards been created?

10. Have we considered the cost implications of eHealth as compared to the simpler remedies that people in rural settings need?

11. Will NDoH consider investing in open source (list of open-source health software) health care software instead of proprietary software?

12. Will NDoH fund the development of community driven health software projects that could be freely (open source) used by anyone?

13. Have we moved closer to addressing the issues of hardware inoperability?

14. What hardware will be required at clinic level for the implementation of the NHI? How will this be maintained?

15. What unique number will be used for the NHI Card?

16. What about our refugees and foreigners who do not have a passport that they can show when applying for a NHI card?

17. Is the NHI card instrumental in creating quality facilities?

12. Health Facilities Assessment Monitoring and Evaluation

It is stated that: “Quality of healthcare must be adequately addressed in both the public and private sectors.” This is crucial in the movement towards NHI.

In 2012, a National Health Care Facilities Baseline Audit was conducted. Facilities were scored on vital measures in the six ministerial priority areas for patient-centred care. Across all health facilities in SA, none of the priority areas had an average percentage compliance score higher than 70%. The highest average percentage score was waiting times (68%), followed by the availability of medicines and supplies (54%), cleanliness (50%) and infection prevention and control (50%), improve patient safety and security (34%) and positive and caring attitudes (30%).

The NHI white paper came out in December 2015. Three years have already passed since this assessment. It is unclear how long it would take for the NHI to be fully implemented. Health facilities should be constantly assessed to ensure that they are “fit” for the NHI.

It is encouraging that the Office of Health Standards and Compliance (OHSC) was created. In its current detail, the White Paper places too much emphasis on the OHSC, the ideal clinic in the purchaser/provider split.

Throughout the NHI white paper, there is a lack of timelines coupled with achievable indicators. Implementation of the NHI scheme will take approximately 14 years and it is important to keep track of the implementation, to determine if the NHI scheme will work.

Accreditation to private facilities should be dependent on the needs of the local community and if the needs are already being met, the government should reserve the right to recommend that the facility be moved to an area where it is needed more.

Questions:

1. When will facilities be assessed again to determine if the quality of standards being provided are adequate? And how often thereafter?

2. Given that health facilities that are eligible would have been certified by the OSHC and accredited by the NHI fund.

3. What is the timeline for accreditation of health facilities?

4. What about those facilities that are not eligible? What would be done with them?

5. What enforcement power will be given to the OHSC? And to whom does the OHSC report?

6. What qualifications will the individuals working for the OHSC have?

7. Is the OHSC instrumental in creating quality facilities?

8. What indicators will be used to ensure that implementation of the NHI is on track?

9. How will we collect data for these indicators?

13. Conclusion

We as young people and public health practitioners recognise and acknowledge the work done thus far by our government, the NDoH and our health minister Dr Motsoaledi. However, we request that any future amendments to the NHI White Paper consider our inputs and answers our questions. Moving forward as young people, we request that we are consulted on all aspects pertaining to the NHI and that the contents of this document are noted and addressed.

Thank you

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If PHM-SA is to fulfil its goals, it needs to seriously provide support to SC members who advocate for these issues and nurture relationships with other organisations and people who do human rights and advocacy work in these areas too.

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