SOUTH AFRICAN NATIONAL MENTAL HEALTH ALLIANCE PARTNERSHIP

National Health Insurance Bill, 2018
Comment by the National Mental Health Alliance Partnership

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The National Mental Health Alliance Partnership (NMHAP) is a coalition of individuals and groups dedicated to the realization of access to quality mental health care in South Africa. As such, the NMHAP appreciates the opportunity to comment on the NHI Bill, published for public comment in Government Gazette No.41725 in June 2018. There are two parts to this comment, the first pertaining to mental health care services, and the second to issues in leadership and governance.

A Mental Health Care Services

The NMHAP commends and supports the Honourable Minister of Health, Dr Motsoaledi, in his endeavours to achieve equal access to quality care for all South Africans and hopes that Universal Health Coverage (UHC) will include people with serious mental illness, mental and intellectual impairment, and psychosocial and intellectual disabilities in equity with others. To this end, we are fully supportive of the inclusion of mental health care already evident in the NDOH Essential Medicines List and Standard Treatment Guidelines.[1] Regarding the NHI Bill, we are pleased to note that, in Section 54(2)(b)(iv), mental health disorders and people with disabilities are included as a vulnerable population group requiring an "interim purchasing of health care services." However, we are still concerned that mental health is not recognised in parity with general health by the Bill. This concern is derived from the following:

- Mental health is only recognised in parity with general health in the preamble in relation to Article 12 of the United Nations Covenant on Economic, Social and Cultural Rights, 1966 and Article 16 of the African Charter on Human and People's Rights, 1981. There is no other mention of the needs of people with mental illness or intellectual disability until Section 54, where they are mentioned only in the context of a vulnerable population group. The Bill itself appears to be concerned only with health, which is not defined as being inclusive of mental health.
- The Bill does not acknowledge the United Nations Convention on the Rights of Persons with Disabilities and Optional Protocol (CRPD), which came into force in 2008,[2] and to which South Africa is signatory.

[1] NATIONAL DEPARTMENT OF HEALTH. 2018. Standard Treatment Guidelines and Essential Medicines List [Online]. Pretoria, Republic of South Africa. Available: http://www.health.gov.za/index.php/standard-treatment-guidelines-and-essential-medicines-list [Accessed 16 September 2018].

[2] UN Convention on the Rights of Persons with Disabilities and Optional Protocol, available from http://www.un.org/disabilities/documents/convention/convoptprot-e.pdf [accessed 13 September 2018]

- The Bill does not acknowledge the Mental Health Care Act No.17 of 2002 (MHCA) other than as a piece of legislation which will require amendment for NHI. The MHCA differs from the other health-related legislation listed in that it regulates mental health care services, which should be funded by NHI in parity with all other health care services. Although the MHCA is to be amended for the purposes of NHI, it must still be observed by NHI, as is the National Health Act No.61 of 2003 (NHA), which also requires amendment.

- Section 2(1) limits the application of the NHI Act to "public and private health establishments, but does not apply to military health establishment", and uses the definition of health establishment in the NHA. There is no application to non-profit "health establishments" and there is no differentiation between "health establishments" which provide health services such as medical treatment and those which provide food, water, and shelter under Section27 and Section28 of the Constitution. Confusion around the scope of a non-profit health establishment is illustrated by the NDOH Policy Guidelines for the licensing of residential and/or day care facilities for persons with mental illness and/or severe or profound intellectual disability gazetted in March 2018.[3] These Guidelines characterise non-profit supported housing of people living with mental illness and/or intellectual disability (PLWMI &/or ID) as health establishments as per the broad definition in the NHA. However, funding support is not guaranteed by the NDOH[4,5] and there is no national service delivery agreement with the Department of Social Development to ensure shelter and food for PLWMI &/or ID.

The implication of these omissions (the term "mental health", the CRPD and the MHCA) is that people with mental illness and/or intellectual disability are regarded as separate beings from the general population, with the inherent risk that their needs will not be funded by NHI in equity with others. While some of these needs, such as supported housing, may be more appropriately funded by the Department of Social Development, the NHI Bill makes no provision for this, although it uses the all-embracing definitions of "health establishment" and "health services" in the NHA. The risk is high that not only the general and mental health needs of PLWMI &/or ID will be unfunded by NHI, their social needs will be unfunded by Social Development as these are perceived as "health."

The dichotomous approach adopted by the NHI Bill, whereby Mental Health is separated from National Health, is inconsistent not only with the CRPD, but also with the Sustainable Development Goals (SDGs), which include mental health in parity with general health in the "Declaration" and in health goal 3. When considering the SDGs, the CRPD, the MHCA, and the Constitution of the Republic of South Africa (the Constitution), UHC of PLWMI &/or ID means that these individuals will be able to use the health and mental health services they need in equity with others. While there may be a need for legislation particular to the legal capacity of an individual during episodes of severe illness or with severe mental impairment,[6] there should be no distinction between any health care users, whether requiring mental health or general health care services under usual conditions. The health service should address the needs of all people for all types of illness according to disease burden, with necessary adjustments made to the health system to accommodate impairment and prevent or address disabilities, including mental, intellectual and /or psychosocial disabilities.

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[3] POLICY GUIDELINES FOR THE LICENSING OF RESIDENTIAL AND/OR DAY CARE FACILITIES FOR PERSONS WITH MENTAL ILLNESS AND/OR SEVERE OR PROFOUND INTELLECTUAL DISABILITY, 16 March 2018, Government Gazette No. 41498

[4] Mental Health Care Act, 2002 (Act 17 of 2002) GENERAL REGULATIONS RELATING TO THE MENTAL HEALTH CARE ACT, 2002: AMENDMENT, 6 November 2014, Government Gazette No. 38182

[5] NATIONAL DEPARTMENT OF HEALTH. 2018. Annual Performance Plan 2018/19 - 2020/21 [Online]. Pretoria, Republic of South Afirca. Available: http://www.health.gov.za/index.php/2014-03-17-09-09-38/annual-performance-plans [Accessed 16 September 2018].

[6] FREEMAN, M. C., KOLAPPA, K., DE ALMEIDA, J. M., KLEINMAN, A., MAKHASHVILI, N., PHAKATHI, S., SARACENO, B. & THORNICROFT, G. 2015. Reversing hard won victories in the name of human rights: a critique of the General Comment on Article 12 of the UN Convention on the Rights of Persons with Disabilities. Lancet Psychiatry, 2, 844-50.

It follows that South Africa should be moving towards health legislation which integrates mental health with general health in one document, and which provides for inter-sectoral negotiation and agreement to address social and other non-health needs.

Therefore, we recommend the following alterations to the Bill:

- **Definitions**
  "Health" to be defined as being inclusive of physical and mental health, and to ensure that it carries this meaning, with all its practical implications, throughout the Bill.
  "Health care provider" to be inclusive of "Mental health care provider" as defined by the MHCA.
  "Health establishment" and "Health services" to each be defined in terms of the scope and coverage of NHI, with delineation of social and other responsibilities of non-health government departments.
  "User" to be inclusive of "mental health care user" as defined by the MHCA.

- **Application of the Fund**
  Section 2(1) – To specify the limits of NHI with respect to non-profit health establishments, according to whichever definition is adopted by the NHI Act.

- **Duties of the Fund**
  Section 5(3) – To amend as follows in italics: The Fund must support the Minister in fulfilling his or her obligation to protect, promote, improve and maintain the health *and mental health* of the population as provided in section 3 of the National Health Act *and section 4 of the MHCA.*

- **Eligibility as Beneficiaries of the Fund**
  Section 7 – This section does not appear to uphold Section27 of the Constitution, which does not differentiate between persons. At the least, the NHI Act must specify that a humanitarian approach must prevail for people with mental illness, impairment or disability and intellectual impairment or disability, regardless of whether they are registered with a PHC facility, in possession of a South African identity document, or of their citizenship or resident status.

  This is considering the following:

  - PLWMI &/or ID often have severe childhood adversity; biological parents and relatives may not be traceable, and the psychosocial and/or intellectual disability may be such that they have difficulty accessing government social and home affairs services. Provision must be made that they are not refused treatment because they are not registered with a primary health care facility or have no South African Identity Document.
  - We recognise that, to ensure sustainability of NHI, South Africa cannot afford to provide UHC to citizens of neighbouring and other countries. However, we believe that excluding the individual from needed health care services, particularly if they suffer from a mental illness which impairs psychosocial and cognitive function, is inhumane and breaches the Constitution.
  - Migrants, refugees and asylum seekers are all at higher risk of mental illness than the general population. Serious mental illness tends to be chronic and relapsing and causes severe functional impairment. The Bill excludes them from mental health care services other than emergency care, notwithstanding their extreme vulnerability.
  - Mental illness worsens maternal and foetal outcomes of pregnancy. However, migrants to South Africa are only entitled to maternal care at primary health service level, even if the pregnancy is high risk.
  - Many travel insurance policies exclude cover of any mental illness, including index presentations.

- **Rights of Users**
  Sections 9(d) and 9(f) to define "unreasonable" and "reasonable" respectively, and to include the need to be aware of people with mental, functional, or intellectual impairment in these definitions.

  Section 9(m) to include a clause referring to the ethical obligation to breach confidentiality if a risk to public health is identified, as in the NHA Section 14(2)(c), or if there is a risk of harm to the user or others, as in the MHCA Section13.

- **Reimbursement for Services Rendered and Referral to Specialists**
  Section 10(2)(c) – To add a proviso that the user's complaint is adequately addressed at the initial health establishment. This must include a proviso that people with difficulty in expressing themselves, explaining their needs, or containing their behaviour, are accommodated with additional time and attention so that the health or mental health need is addressed appropriate to the level of severity of the condition.
    - Such individuals must not be penalised for seeking health care at a more specialised service level if the primary health care provider has not identified or treated the health or mental health problem appropriately or has not recognised the need to refer the user.
    - Psychosocial and intellectual disability of PLWMI &/or ID places them at risk of having delayed or inadequate health care.

- **Health Service Benefits Coverage**
  Section 11(2)(a) and (b) – Must include intersectoral referral pathways, with entry into the health system by referral from non-health sectors such as Social Development, Justice, Correctional Services, and Education. Such referral into the health system must be appropriate to the severity of illness and level of health need, particularly for mental health care users, who often present first to non-health sector services. Severe illness may not be recognised as an emergency if not disruptive or acute, but still requires urgent specialist rather than PHC attention.

  Section 11(4) – The Benefits Advisory Committee must consider burden of disease and population needs, not only the potential funds available. Recommendations must be in proportion to desired health care outcomes, not to funding. Funds, and their judicious use, must then be allocated according to the desired health outcomes.
    - Related to the nature of the illness, impairment, and/or disability, PLWMI &/or ID are at risk of not receiving financial protection globally. Making recommendations based on available funds without considering health outcomes places them at high risk of neglect.

- **Benefits Advisory Committee**
  Section 25(1) – To change "may" to "must"
  Section 25(2) – To also include:
  - a member seconded by the WHO Department of Mental Health and Substance Abuse
  - two health care providers recognised nationally for clinical expertise, one of whom has expertise in psychosocial and/or occupational intervention and rehabilitation, and the other a generalist medical practitioner.
    - The Benefits Advisory Committee is to determine the health service benefits and types of services to be reimbursed at each level of care, and to determine the detailed and cost-effective treatment guidelines, by which the services of all health care providers will be evaluated.
    - The scope of the health benefits and guidelines to be determined requires a perspective on health care provision, scope of practice, and service delivery which may not be in the

purview of heads of medical schools and other members of the Benefits Advisory Committee

- **Stakeholder Advisory Committee**
  Section 27(1) – To also include two user-representatives of persons with disabilities, one of whom to represent those with a psychosocial disability.

- **Payment of Service Providers**
  Section 39(2) – To include specialist level mental health services from the district or community setting.
    - Providing accessible, community-based specialist mental health services is a necessary health system adjustment to accommodate the mental, intellectual and/or psychosocial impairment and disabilities of PLWMI &/or ID.
    - In South Africa the majority of PLWMI &/or ID are deinstitutionalised and thus community dwelling, even those with very severe illness, functional impairment or disability. Persisting with a solely hospi-centric model of mental health care will not only deny accessible care to the user, it will have costly negative effects on the health system and society, as PHC practitioners and the PHC system are not equipped with the necessary skills to manage severe mental illness.
    - Positioning a specialist level service in the district setting provides greater opportunity for upskilling of and collaboration with PHC practitioners and other health workers, as well as inter-sectoral collaboration with local non-health and non-governmental sectors. This should help with achieving UHC for PLWMI &/or ID.

- **Transitional Arrangement**
  Section 54(2)(b)(iv) – although an interim arrangement is welcome, the care of PLWMI &/or ID cannot just be an interim measure. Because most serious mental illness is chronic and relapsing, starting usually in youth and often persisting throughout life, interim measures will not clear backlogs. Proper development of mental health care services, with appropriate human resource organisation and suitable infrastructure, is needed to ensure adequate promotive, preventative, curative, rehabilitative and palliative mental health care.

  Section 54(4)(f) and (g) – To add a category of community-based specialist level services, at least for mental health care if not for other specialties. This should include provision for multidisciplinary team assessment, care, treatment and rehabilitation of index presentations and of maintenance care of PLWMI &/or ID from the community platform. A flexible approach to the human resources should be incorporated so that task-sharing within the specialist level service, with PHC practitioners, and with relevant members of the community is enabled.
    - The implications of the current arrangement are that all accessible ambulatory health and mental health care is within the scope of practice of PHC practitioners, and that any need for specialist level assessment or treatment requires hospital care. There is no provision for ambulatory, accessible, specialist mental health care which may prevent hospitalisation, and may result in better psychosocial functioning and quality of life of the individual.
    - The tendency of hospital-based mental health care is to focus on relief of acute psychiatric symptoms rather than improvement of long-term function and prevention of relapse, which should preferably take place in the context of the user's community and daily life. In addition, hospital based mental health care is poorly accessible to children, adolescents, women, the elderly, and anyone with severe functional impairment or psychosocial disability who is not aggressive or disruptive.
    - There is no reason why specialist, including tertiary level, mental health care must be restricted to hospital services as hospital-based equipment and infrastructure is not

required. What is required for community-based specialist level mental health services is qualified personnel, physical space, and simple equipment for psychological assessments and occupational therapy.

- Outreach, either in person or via telemedicine, from hospital to community-based services may be the only option in certain, mainly rural, areas. However, it does not replace community-based mental health services which should become integral to the district health service although not PHC themselves. Furthermore, outreach would itself require additional staff for this purpose at the hospital level.

B Leadership and Governance

The entire health system depends on ethical leadership and governance with the appropriate expertise. This is especially as NHI proposes a single-payer system.

We have the following serious concerns and recommendations:

- **The Board of the Fund**
  That the Board is recommended by the Minister and appointed by Cabinet, following interviews by a Cabinet appointed committee raises questions about its independence. From the appointment process described, there could be a high risk that the Board members may be political appointees. In addition, there is no requirement in the Bill for transparency in the appointment process or the functions of the Board. However, the Chief Executive Officer is directly accountable to the Board (Section 22(1)(a)) and carries out responsibilities which are subject to the direction of the Board (Section22(2)), and the Board determines its procedures in consultation with the Minister (Section 19).

  The Board is expected to govern the Fund in accordance with the provisions of the Public Finance Management Act. However, its functions include governance of the Fund, its operational and administrative functions, its policies, practices and decisions, the employee organisational structure, and determination of which health benefits are procured. These functions appear to stretch beyond financial management per se and will have a direct bearing on the health system. Nevertheless, only "appropriate expertise", which is a subjective quality, is required for appointment as a Board member.

  True external accountability is needed. The Board is governing a Fund that will provide health services for the entire nation, at the nation's expense. It must be accountable to the Public directly, not only via Parliament. Therefore, the following must be specified in the NHI Act:

  1. Oversight by an external juristic body with no political connections in the appointment process of Board members.
  2. Transparency with open publication regarding all nominations, the qualifications of those nominated, the interview processes, appointments, and functions of the Board.
  3. Public access to information regarding the remuneration of the Board as well as the governance of the Fund, including all expenditure and organisational structure.

- **Provincial Departments of Health**
  Provincial Departments of Health are included via a representative in the Benefits Advisory Committee and as providers of health services in co-ordination with the NDOH. There is no evidence of provincial involvement in health policy or national plans other than through the National Health Council, which may reach a quorum even if no provincial heads of department are present.

The implication is that national health policies and strategic plans may be developed without adequate input from provinces, and thus may not be implementable at provincial level.

The NHI Act should make provision for:

1. Full provincial involvement in the development of national health policy and plans.
2. Such policy and plans must be ratified by provinces as being relevant and implementable by provinces before being gazetted by the NDOH.
3. Feedback mechanisms for rapid adjustments to be made when necessary, i.e. when problems in implementation represent a risk to users which cannot await standard quality assurance mechanisms of change.

- **Health Care Providers**

  The Bill sets out obligations of the Fund in terms of payment and accreditation of health care providers, and duties of health care providers with respect to the rights of users. The Fund has a duty to "determine prices annually after consultation with health care providers, health establishments and suppliers in the prescribed manner and in accordance with the provisions of this Act" (Section 5(1)(f)). However, there is no provision for direct health care provider representation on any of the committees. The heads of medical schools and other members of the Benefits Advisory Committee, and the statutory councils, tertiary education institution and other members of the Stakeholder Advisory Committee do not have any scope in determining working conditions or reimbursement needs of practicing health care providers. This leaves only indirect representation on the Health Benefits Pricing Committee and one labour representative on the Stakeholder Advisory Committee through which the Fund may consult with health care providers regarding the cost of services provided. It is not possible to provide quality health care without addressing the needs of health care providers. The provisions of the Bill run the risk of dissatisfied and frustrated health care providers, with consequences of increased emigration or strong unionisation. Neither of these situations bode well for South Africa.

  The NHI Act should:

  1. Provide for health care provider consultation and negotiation in a properly structured and representative forum.
  2. Specify health care provider representation on the Health Benefits Pricing Committee and the Stakeholder Advisory Committee.

Conclusion

We thank the Minister of Health and the NDOH for the opportunity to comment on the NHI Bill. Overall, we welcome the Bill and the intentions to strengthen and reorganise the South African health system. Our comments are in the interests of an improved system which will serve the population of South Africa, improving the health and mental health of all. We look forward to a health care system does not discriminate between users, regardless of race, socio-economic status, or type of illness, impairment or disability.