



Health for All Now!

**People's Health Movement**

South Africa

PEOPLE'S HEALTH MOVEMENT SUBMISSION ON  
NATIONAL HEALTH INSURANCE BILL

21 Sept 2018

**1 INTRODUCTION**

The People's Health Movement South Africa (PHM-SA) is the South African Chapter of the People's Health Movement (PHM), a global network of grassroots activists, civil society and academics, predominantly from low and middle income countries with a presence in approximately 80 jurisdictions. PHM's understanding of "Health" corresponds to the World Health Organisation's definition of health as a state of complete mental, physical and social well-being and not merely the absence of disease. Therefore, PHM-SA does not limit its work to advocating for improved healthcare services for all. It also works with communities and civil society organisations to improve the social determinants of health (SDH), i.e. "the conditions in which people are born, grow, work, live, and age, and the wider set of forces and systems shaping the conditions of daily life. These forces and systems include economic policies and systems, development agendas, social norms, social policies and political and economic systems."

1. This submission seeks to contribute to development and implementation of the National Health Insurance scheme. The Peoples Health Movement of South Africa (PHM SA) supports the principles of the NHI Bill - of equity, social solidarity, health care as a human right and public good, and the provision of effective, universally accessible, comprehensive, high quality care in an affordable and efficient manner, paid for via a single progressive NHI Fund, largely through a prepayment, weighted capitation mechanism. The intent of the NHI Bill is strongly supported by PHM SA, but the Bill contains several deficiencies and anomalies which need to be rectified if the human right to health is to be achieved for all the people who live in South Africa. Our comments and criticisms below are provided in a constructive effort to enhance the NHI Bill.
2. We also believe that the Bill should have been better consulted with the broader South African public and that a longer time for public consultations should have been provided. Insufficient efforts have been made to raise public awareness or support decentralised consultation given that the NHI is a highly complex development. Communities and civil society organisations needed more time and engagement to be really in a position to input on the Bill.
3. We also believe that the consultations on the NHI Bill have been constrained by a lack of access to information, a constitutional imperative when appraising new legislation. Facilitating and expanding discussion on the NHI Bill would only be effective if the discussions are informed by adequate information around what influenced the various positions presented in the NHI Bill. While it is known that there have been many technical background reports produced which informed choices made in the NHI Bill, few of these technical reports have been made available to the public. For people to understand and support the positions adopted in the NHI Bill, the information used to arrive at those positions should be transparent and easily

available. It is therefore imperative that all the technical reports related to and prepared for the NHI be made publicly available by posting them on your website, including any evaluations of the NHI Pilot sites. This will immediately give many people access to this crucial information.

4. Nevertheless, despite our concern over the need for more public consultation and preparation, PHM is submitting these comments based on our extensive interactions with communities and Civil Society groups over the NHI over the past 8 years.
5. Going forward, we believe that a specific mechanism and process of ongoing stakeholder involvement, engagement and interaction needs to be instituted, to assist with popularising, defending and implementing the NHI. As with the land appropriation consultative process, an active process of public engagement is not only required but is mandatory in terms of our Constitutional commitment to participatory democracy. We should learn from the process of public engagement around land appropriation which has been shown to have some challenges, and implement a much more geographically extensive and conversationally in-depth, genuine discussion around what is required to improve the health of all the people in South Africa. In practice, this means that the National Department of Health must embark on a large scale consultative process. Is the NHI not important enough for the minister, deputy minister and/or senior National Health Department officials, to visit every town and city in South Africa to explain its essential details, and more importantly to listen to the responses of the people?

## **2 PEOPLE'S HEALTH MOVEMENT'S GENERAL POSITIONS ON THE NHI BILL**

### **2.1 Funding and purchasing of services**

6. Corruption: The NHI Fund will concentrate huge sums of money. The potential exists for this enormous fund to be looted. Given the enormity of the NHI Fund, measures to prevent and combat corruption should be strong, clear and enforceable.
7. However, the oversight structures proposed in the Bill raise some concerns
  - a. Firstly, the establishment of an internal investigating unit (in section 22 of the NHI Bill) to combat fraud which is under the direct control of the CEO of the NHI Fund is grossly insufficient and is likely to have its independence compromised given that it is directly reports to the CEO who in turn reports to the NHI Board and the minister. Noting the potential for the facilitation of fraud by the people to whom it must report, the ability of the investigating unit to effectively combat fraud at a high level is doubtful. We believe the reporting lines of the investigating unit should be directly to parliament and not to the CEO or to the NHI Board.
  - b. Additionally, the size and competency of the investigating unit needs to be expanded, given the large number and types of transactions involving large sums of money into which the NHI Fund will enter. The size and competencies of the investigating unit need to be carefully thought through and clearly specified. Probity of members of the unit must be a priority consideration when members are recruited and the Unit must be constituted such that its honesty and integrity cannot be doubted.
  - c. Thirdly, the reporting lines and appointment of the Board potentially limits its independence. This Board of 10 people has extensive powers including strategic purchasing, buying, selling property, taking out loans and making investments. It is appointed by the Minister and primarily answerable to the Minister. This concentrates too much power in the hands of a few individuals, whoever they may be, and locates too much indirect and unaccountable authority with the Minister. The Bill should include further mechanisms for accountability and oversight which are legislated.

8. We note as well that eligibility for membership of the NHI Board specifically excludes public sector health providers and persons with “personal or professional interests in the health sector.” This may mean that no public sector health workers will be permitted to serve on the Board. This clause could result in the exclusion of the voice of workers at public facilities and health science faculties because of their professional interest. Such an exclusion would not serve to protect the NHI fund nor be in the interests of public oversight of the Fund.
9. We also note that at district and sub-district level, the NHI will rely on the capacity and integrity of local managers to avoid over-costly charges, unless there is considerable strengthening of technical capacity of local managers to undertake such oversight and that mechanisms for this oversight are greatly enhanced. If not, then the door will be opened to over-billing and other forms of fraud and corruption.
10. The sources of income for the NHI Fund provided for in the Bill are vague and ambiguous. The somewhat more substantial detail which was contained in the Policy Paper preceding the Bill has been removed. The Bill also makes no mention of the 2018 VAT increase – which it should, since regressive measures such as a VAT increase have adverse health impacts. It also remains unclear whether this increase will in any way assist the funding of the NHI scheme.
11. Since the NHI is being established to improve the health of all the people in South Africa it is crucial that it does not indirectly have a deleterious effect on health by imposing regressive taxation such as an increase in VAT or a surcharge on salaries, or a flat rate increase in income tax to fund it. Such funding arrangements have the potential to entrench inequality and worsen health status.
12. The NHI funding mechanisms should be decided by a transparent, participatory and evidence-based process that is insulated from the private sector influencing decision-making. Engagements with all stakeholders – communities, civil society, private sector, research institutions and others – should be consistent with transparency and democratic principles. Participation, particularly of vulnerable communities, should be actively sought in the policy making process.
13. The social solidarity principle of the NHI demands that progressive taxation such as a variable incremental increase in income tax, an increase in company tax or a salary exempted financial transaction tax be used, thereby allowing those with greater financial income to support those with a lesser income. Hence the NHI Bill should contain funding information thereby allowing parliament to ensure that it is funded in a health enhancing progressive manner.
14. Given that the mechanisms for payment of accredited service providers are vague in the Bill, we are worried that there is an intent to enrol medical schemes to perform this function, a concern reinforced by membership of the transitional structures outlined in the gazette of July 2017.

## **2 2 Discrimination**

15. The Bill discriminates unfairly against non-South Africans. Both refugees who have been granted asylum and those awaiting their decision on their asylum application are entitled to only a selected set of services under the NHI. For undocumented migrants without any refugee status, there is no entitlement under the NHI Bill. The NHI Bill has regressed on the commitment to universal health coverage for the ‘entire population’ present in the preceding White paper because it only commits to providing universal health coverage for South African citizens and permanent residents.

16. Further, the NHI scheme implies that the health services to be afforded to migrants with legal status will not be equivalent to that afforded to South Africans and permanent residents because they will be provided with 'basic health coverage' rather than equivalent coverage under universal health care. Far from complying with section 27 (g) of the Refugees Act 130 of 1998 as amended, it seems the NHI scheme seeks to establish exceptional status for legal migrants with reduced coverage – which would appear to be in violation of Section 27(g) and international human rights commitments with regard to refugees. There has been no mention of health care coverage to undocumented migrants and, given the number of undocumented migrants in South Africa, this is concerning due to potential discrimination and denial of access to health care.
17. A further contradiction is that the NHI scheme states that asylum seekers would be entitled to emergency care (paragraph 122), but that undocumented migrants would have to pay for their emergency care. Since the South African Bill of Rights frames access to emergency medical services as a right for 'everyone' (not just citizens or those who have been officially recognized as refugees), imposing the cost for emergency medical care on undocumented migrants is highly discriminatory, as most undocumented migrants will likely not be able to pay for services essential to preserve their lives. Despite the fact that there is considerable research into the number of migrants in South Africa, their socio-economic status, their health care utilization and obstacles to care, none of these data are presented in the NHI policy as a basis for deciding on benefits for refugees.
18. In the Constitutional Court case, *Khosa v The Minister of Social Development*, the court held that a reasonable measure cannot unfairly discriminate against a group. Whilst citizenship is not a listed ground of discrimination under section 9(3) of the South African Constitution, the Constitutional Court held that the legislation limiting access to social assistance grants to citizens amounts to unfair discrimination as it impacts on the group's human dignity.
19. We note that this position on migrants treats them as interlopers and ignores the social, cultural and economic contribution they make to the country. Refugees, asylum seekers and undocumented migrants, in addition to adding a vibrant cultural dimension, contribute to the economy of the country by stimulating economic growth and contribute to the fiscus via indirect taxes (VAT and excise taxes) and often via direct taxes as well.
20. The exclusion of refugees and migrants from the same health care entitlements as South Africans and permanent residents is short sighted and will disrupt the health system. Refugees, asylum seekers and undocumented migrants will need the same health care services as citizens and permanent residents. Denying them such regular care will simply lead them to end up accessing emergency services instead or as a result of deterioration of their condition. This will result in the clogging of already over-burdened emergency services with patients who would more effectively and efficiently be catered for via NHI funded outpatient services. Hence limiting the services provided to refugees and asylum seekers and totally excluding undocumented migrants from the NHI, will actually result in an increasing magnitude and severity of the burden of disease for a large group of people and will ultimately result in the collapse of emergency services, which then threatens the health of everyone. To avoid this and to affirm the human health rights of everyone, procedures for issuing people without any documents, with for example, NHI cards or an alternative form of non-discriminatory documentation, would have to be established.

## **2 3    The Committees**

21. Composition of the Benefits Advisory Committee and Benefits Pricing Committees have no civil society or labour representation. Given the current membership described in the Bill, these committees are likely to be biased towards hospital centred care. Attention should be

paid to increasing the diversity of membership of these committee, particularly in broadening membership to participants able to bring community voice to these critical decisions.

22. The NHI Bill establishes a committee for tertiary health services but creates no similar structure for primary care. The country's health services are already hospi-centric and particularly dominated by tertiary and specialist care. This means that the NHI is likely to end up focusing resources and attention on tertiary services at the expense of primary care and the wider needs of communities. We believe the NHI Bill should include a committee charged with strengthening community orientated primary health care.
23. We also believe that those structures that decide on benefits must be accountable for the reasonableness of their choices of the benefits they include in the package. The reasoning behind their choices should be open to public scrutiny, including the evidence upon which they are based and how they apply in local contexts.

## **2 4 Public Participation**

24. There is no room in the NHI and its committees as currently constituted for meaningful public participation. While the White Paper made a brief reference to health committees (mandated in terms of the National Health Act), the NHI Bill makes no reference to any structured community participation in the NHI. We believe this is a serious error and undermines the Constitutional commitment to participatory democracy.
25. The system of health committees and hospital boards has been recognised as labouring under many weaknesses, and has not lived up to the expectations of these structures as vehicles for community participation. The National Department of Health should prioritise the building of capacity and support for these structures so that they can act as vehicles for meaningful community participation in health governance.
26. The NHI Bill should reflect in its committees and structures a formalised link with health committees and hospital boards, in ways that allow local communities a say in the decisions of the NHI affecting access to health care.

## **2 5 Human Resources**

27. An HRH plan is required urgently to ensure the development of a robust public health sector, especially at district level and below. This plan:
  - a. Should include a focus on CHWs and other types of HWs other than doctors (specialists) and nurses;
  - b. Should be urgent (Phase 2 not Phase 3);
  - c. Should be developed by a more diverse committee than currently framed in the bill dominated by medical school deans;
  - d. Should include a plan for building the capacity of staff involved in Commissioning Units for Primary Health Care and generally for district and sub-district staff;
  - e. Should be complemented by urgent action, especially ~~is~~ to unfreeze critical posts, with particular attention to equity – and to accelerate the implementation of the CHW policy.
28. The development of an HRH plan should be moved to phase 2 not phase 3 because it is urgent and cannot await establishment of the financing mechanisms.

29. The HRH committee should not only draw on medical schools but rather include the full range of training institutions.
30. There should be strong and meaningful consultation with health workers, particularly CHWs, to ensure that health workers' conditions of service are adequately addressed.
31. In section 37 of the NHI Bill it is stated that the Contracting Unit for Primary Health Care will have ward-based outreach teams (WBOTs), but there is no mention in section 38 about their accreditation nor in section 39 about their funding. Given the demonstrable benefits that Community Health Workers in WBOTs can deliver at low cost it is imperative that they become a prominent feature of the NHI. Clarity on the role, functions, accreditation and funding mechanism for Community Health Workers in WBOTs within the NHI, needs to be provided within an integrated HRH plan.

## **2 6 Provider accreditation and member registration**

32. Given the current levels of infrastructure and functioning of public sector facilities, there is a greater likelihood of urban and private providers being accredited than public and (especially) rural providers, which is likely to aggravate already existing urban/rural inequity.
33. The Bill should set out how providers, particularly in the public sector serving marginalised populations, who fail to secure accreditation, will receive appropriate support to address the factors preventing their accreditation. This relates to the proposal above (see paragraph 38 below).
34. Many people do not have birth certificates and Identity Documents (ID's). This may limit their access to health care as they cannot register without them. Mechanisms should be put in place to mitigate against these bureaucratic hurdles, particularly for poor and vulnerable groups.

## **2 7 Strengthening of the Public Sector**

35. About 90% of public sector facilities did not reach the OHSC<sup>1</sup> benchmark in the last OHSC audit.

What is the plan over the next 8 years to bring the vast majority of facilities in the public sector up to that benchmark? How will they receive appropriate support to address the factors preventing their accreditation?

36. We are dismayed that there is not one structure in the NHI Bill that specifically addresses the strengthening of the public sector. The committees described by the Government Gazette Notice 40969 (NHI Implementation: Institutions, bodies and commissions that must be established) do not include one on strengthening primary health care, nor on improving public health care services. Yet primary health care is declared to be the heartbeat of the NHI and public health care services are the very backbone of health services, currently serving 84% of the population. It is therefore inconceivable why there are no committees to strengthen primary health care and services in the public sector.

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<sup>1</sup> Office of Health Standards Compliance - an independent body established in terms of the National Health Amendment Act of 2013 to ensure that both public and private health establishments in South Africa comply with the required health standards. <http://ohsc.org.za>

37. Strengthening the Public Sector must therefore be a priority, and not come after creation of the NHI fund. The only mechanism addressing strengthening the quality of public sector services appears to be the OHSC and Ideal clinic systems.

However, these are QA/QI systems<sup>2</sup> which do not release any resources that might be needed, such as physical infrastructure, a rapid and substantial increase in human resources and their skills, especially in leadership and governance, mechanisms to ensure fair redistribution of human resources and procurements of disposables and equipment. These latter needs should be linked to existing and new Intellectual Property policies, use of TRIPS flexibilities<sup>3</sup> and recognition of the Right to Enjoy the Benefits of Scientific Progress.

38. We believe the NHI Bill should include a Commission for Strengthening Public Sector Services, that includes in its mandate mobilising the resources to support investment in physical infrastructure, facility refurbishment, establishment of new facilities and purchase and maintenance of equipment needed. Appropriate budget should follow these imperatives. The Commission should also address weak governance, poor management and absent leadership in the health system, and make sure that procurement is freed up from opportunistic “tenderpreneurship”<sup>4</sup> that has become insidious in the health sector over the past years. This requires massive investment in training institutions, such as universities, since trainee enrollments will need to escalate rapidly over the medium- to long-term in developing such capacity.

## **2 8 Preventative Care**

39. Prevention is hardly mentioned in the Bill and the key stewardship role of the Department of Health for population health, through the District Health System, appears to be even further marginalised by the preoccupation of the NHI with hospital care, tertiary services and packages of benefits dominated by curative care.
40. This is despite the fact that all four of the quadruple burden of disease clusters affecting South Africa (MCH conditions, NCDs, HIV/AIDS&TB, and injuries and violence) have substantial contributions from upstream factors that are better managed through preventative services. In this sense the NHI risks reducing the right to health to the right to medical treatment unless a serious and detailed (and intersectoral) health promotion and harm prevention plan is drafted.
41. The NHI Bill describes prevention in terms of services delivered by designated providers at a Primary Health Care level (see 54.4(f)). This is, firstly, a misnomer, as Primary Health Care is a descriptor reserved for characterising a health system in line with the vision of Alma Ata and not a level of care. Secondly, this limits the conception of prevention under the NHI to a very narrow idea of personal services. As we know, many of the most effective preventive strategies are population-based rather than individual-based. The NHI Bill needs to refocus its attention on primordial, primary, secondary and tertiary prevention as part of its packages.

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<sup>2</sup> [Quality Assessment and Quality Improvement systems](#) (QA/QI) - described as “systematic, data-guided activities designed to bring about immediate (or nearly immediate) improvements in health care delivery”, and the combined efforts of everyone to make changes that will potentially lead to better patient outcomes, better system performance, and better professional development

<sup>3</sup> <http://www.who.int/bulletin/volumes/91/7/12-115865/en/>

<sup>4</sup> <https://en.wikipedia.org/wiki/Tenderpreneur>

42. In the White Paper, a National Health Commission was charged with coordinating upstream preventive action across sectors. However, this Commission has not been included in the NHI Bill meaning there is no mechanism at all for engaging inter-sectorally (across government departments) for health. This is a very serious gap that needs to be addressed.

## **2 9 Rural health care**

43. The Bill lacks attention to obstacles to care for rural populations, especially concerning physical barriers to access such as patient transport. Whereas the White Paper provided for the NHI to cover transport of patients to get to care, the NHI Bill speaks only of covering ambulance transfer from one level of care to the next, only once a patient has accessed the system. We believe it is important for the NHI to cover transport to the primary care site, where appropriate.

## **2 10 The Design of the Fund and Interim Arrangements**

44. It is critical that the NHI fund retains its commitment to a Single-payer system. There must be no concession made in finalising the Bill on this point as the monopsony<sup>5</sup> power of a Single-payer is all that will enable the Fund to secure prices for services that will enhance access to care.
45. Secondly, although the Bill makes no mention of differentiated packages, the Minister's presentations on the Bill continue to refer to what is called the consolidation of funding streams into five groups (formally employed in large companies, formally employed in SMMEs, employed in government, self-employed and unemployed). This remains a concern because it is likely that the five funding streams will translate into different benefit packages. The danger is that once such differences are established, these differences, meant to be merely transitional arrangements, will be difficult to reverse – as confirmed from international experience.
46. We welcome the Minister's commitment to starting with those who are uninsured – elderly, children, rural people, the disabled. But, simultaneously, it needs to be guarded against that there will be differential packages of care for these groups.
47. Although there was no mention of making medical scheme membership mandatory in the NHI Bill (a development mentioned in the July 2017 Gazette), we are concerned that this might still be on the cards. Such a move would amount to a rescue package (potentially with public funding) for the ailing medical schemes sector desperate for members. It would be a complete contradiction of the intention of the NHI were this to happen, since it would be using public money to prop up a fatally flawed private system that is not sustainable.
48. The Bill states that payment of private providers should be at the lowest possible cost but does not explicitly state that there will be one price for public and private providers. We believe the Bill should state this unequivocally as this is an important safeguard against private sector contracting at exorbitant or inflated rates.
49. We also note that the NHI Bill appears to use the terms Primary Health Care (PHC) and primary care interchangeably. This undermines the holistic concept of PHC as a framework around which to organize a health system. The Bill should be revisited with this distinction in mind so as to ensure the NHI is a system for health rather than just a grand insurance scheme.

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<sup>5</sup> Monopsony - a market situation in which there is only one buyer



### 3 A PEOPLE'S NATIONAL HEALTH INSURANCE

50. A People's NHI<sup>6</sup> should ensure community participation, prioritise equity, develop a health system that is Pro-public, supported by a Single Payer, providing universal benefits equally to all and based on Social Solidarity through public Mobilisation.

51. This means:

- a) Single-Payer system that does not allow the medical schemes industry to determine NHI design.
- b) Cross-subsidisation of the poor and ill by the rich and healthy through progressive tax.
- c) Comprehensive benefits including prevention, health promotion, rehabilitation and palliation.
- d) A strong public sector – particularly in rural and underserved areas, and particularly at lower levels (district and sub-district);
- e) A coherent unified district health system in which the NDOH exercises stewardship.
- f) Sufficient numbers of appropriately trained, motivated, adequately paid and supported staff and a large increase in CHWs with increased scope of practice.
- g) A Human Resources plan developed by a range of stakeholders with attention to equity.
- h) Strong management and leadership skills, able to create spaces for reflection and learning, developed in partnership with training institutions who receive additional long-term funding to do this.
- i) A health system free of corruption and maladministration.
- j) A mix of public and private providers on the basis of population need, rather than supply.
- k) Investment in strong community participation structures.
- l) Equitable representation of different sectors on NHI committees without Conflict of Interest.
- m) Focus on equity of the whole health system to start rather than medical scheme needs.
- n) Give preference to the needs of the most vulnerable
- o) A health system that translates the Right to Health into reality

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<sup>6</sup> See <http://phm-sa.org/nhi-bill-welcome-but-flawed/>