PHASA

Public Health Association of South Africa

WRITTEN SUBMISSION TO THE

PARLIAMENTARY PORTFOLIO COMMITTEE ON HEALTH, ON THE

NATIONAL HEALTH INSURANCE BILL [B11 – 2019]

CONTENTS

INTRODUCTION

1. The Public Health Association of South Africa (PHASA) is a registered Section 21, Not for Profit Organisation, dedicated to promoting health and health equity for all South Africans. The PHASA provides a unique forum for the development of professional, academic, and societal networks in South Africa and Africa. Our members include public health practitioners, researchers and civil society activists with a shared commitment to ensuring that every person living in South Africa has access to quality health services, and a living and working environment that is conducive to physical, mental, and social well-being.

2. The PHASA community welcomes the release of the National Health Insurance (NHI) Bill, and thanks the National Department of Health (Department) and Parliamentary Portfolio Committee for Health, for the opportunity to comment on it.

3. As a community, we are committed to working alongside the Department in advocating for, formulating, and implementing health system reforms in line with the principles of quality healthcare and Universal Health Care (UHC).

4. As a collective, we recognise that the inequalities and injustices that pervade South African society, including inequalities in access to care, in quality of care received, and in standards of living, are a result of the country's apartheid history. However, we also recognise that these injustices and inequalities have proven intractable despite 25 years of democracy.

5. We also note that these inequalities in health and access to healthcare are, in large part, a result of the fragmented South African health system i.e. an overburdened and under-resourced public sector, and an inefficient and largely unregulated private sector. The misdistribution of resources between these two sectors constitutes a catastrophic injustice that risks destabilising the foundations of South African society.

6. We believe that equity in health cannot be achieved without equitable distribution of both health and related resources, and without reducing the burden of paying for health care.

7. We value the goal of ensuring financial protection from the costs of health care, and recognise that cross-subsidisation requires the pooling of revenue to facilitate active and strategic purchasing of health care services, based on the principles of universality and social solidarity.

8. We support the principle of UHC and the intentions of the Department's move towards a NHI. However, we simultaneously share concerns about certain aspects of the proposed NHI Bill.

9. We fear that that aspects of the Bill, as it currently stands, risks further ingraining the very inefficiencies and inequalities it seeks to counter.

10. We hope that these comments will contribute meaningfully to the current discussions and deliberations on the most effective, efficient, and equitable means to introduce NHI and to provide UHC for all South Africans.

COMMENTS AND SUGGESTIONS ON THE NHI BILL

Chapter 1: Purpose and application of Act

11. The aim of the Act is to establish the NHI Fund in order to fund the provisions of UHC, though the Bill also introduces organisational and structural changes to support functioning of a single purchaser and single payer funding system. Given the uncertainty regarding feasibility of certain proposed structural changes, which we think should thus be given more consideration before being legislated in the Bill, we believe that the Act establishing the Fund should be written in a way that does not hinder future legislative processes, especially for issues that are not inherently related to financing.
    Thus, we suggest that sections of the current Bill that touch on arrangements not directly related to the establishment and maintenance of the Fund should either be removed, or that the level of detail around these other arrangements be reduced; to allow more time to consider the most effective proposals and to allow for learning from experience to decide on best potential future models.

12. The NHI Bill as currently formulated is essentially a standalone, independent piece of legislation, largely unrelated to much else in the National Health System.
    The Bill would be much improved if the financing mechanism underpinning the provision of the NHI were better located and explicitly linked to the National Health System, specifically in reference to the National Health Act, which is only mentioned briefly in the annexures together with other legislation that requires amendment. The National Health Act [61 of 2003] and the White Paper for Transforming Health in South Africa 1997, were foundational documents in formulating the rationale for the NHI Bill and they should work together to give effect to UHC, which the NHI Bill cannot do on its own.

Chapter 2: Access to Health Care Services

13. It is recognised that the NHI Bill is aligned with provisions set out in the Constitution, the National Health Act, the Refugees Act, and the Immigration Act, as relates to refugees' rights to access health care services in South Africa. However, there remains much concern and debate around the lack of full population coverage and the restricted access to healthcare services for asylum seekers and illegal foreigners. There are human rights considerations as well as the potential impact of communicable diseases that are not notifiable, including HIV, on overall population health. The increase in number of foreigners who are living illegally in South Africa emerged over many years and was due to the interaction of many complex factors. The number of illegal foreigners in the country has been estimated to be as high as approximately 10% to 15% of the current population[1]. Notwithstanding the Department of Home Affair's efforts to fix and strengthen the immigration system; we believe that, given the current context, it would be important at a population health level, for asylum seekers and illegal foreigners currently in the country, to be afforded the same rights as refugees, to access health care services.

14. Section 5 on registration of users will restrict access to health care for those who might not have been able to register e.g. due to a lack of documentation identified in section 5(5), which could result in hindering access to health care for the most marginalized sectors of the population, and further entrench health inequity in the country. Access to health care services might similarly be prevented in emergency situations.
    Thus, we recommend that explicit provisions be made in the NHI Bill, for how users without documentation will be registered in the system and retain their right to access health care services despite not having documentation.

[1] Eisenberg, G. Is it time for a blanket amnesty for illegal foreigners living in South Africa? Daily Maverick. 2019 Aug 28.

15. Section 6 (o) outlines the right of users to purchase health care services not covered by the Fund, through alternate funding mechanisms. This has implications for the package of health care services that will, or should be, offered by accredited health care providers, and for health care service providers whose scope might fall outside the NHI funded benefits package. Additionally, there might be the case where unaccredited providers may decide to offer services not provided for in the Formulary, which could in turn impact performance of the accreditation system, the organisation of health services in a region, and the quality of care provided.
    Ultimately, the lack of clarity surrounding organisation of the service delivery platform and the benefits package needs to be addressed, albeit be via alternate prescripts and legislation, before many decisions related to the rights of users can be appropriately determined.

Chapter 3: National Health Insurance Fund

16. The Bill stablishes the Fund as a Schedule 3A autonomous public entity, yet the powers of the Minister are heavily concentrated throughout the structure of the Fund, likely undermining its autonomy. The Bill provides for significant centralisation of decision-making power with the Minister, including for very technical issues raising the question of accountability and transparency.
    The Fund should be ultimately accountable to parliament, and the powers of the Minister should be reduced to minimise the risk of political co-option. International evidence has shown the importance of having long-term vision that is not undermined by the five-year political life cycle of a Minister[2], and requires leadership that is vulnerable to political motivation.

Chapter 4: Board of Fund

17. Sections 13 (1), (3), (8), and (9), grant extreme power and authority for appointment and removal of Board members, to the Minister of Health. There are no mechanisms in place to ensure that a Minister is not vulnerable to potential political influences that might lead to politically motivated appointments, rather than purely technical experts, who would be in a better position to provide unbiased and independent oversight.
    International evidence has clearly demonstrated the importance of the clear separation of political and administrative powers across every level of the public health system[3].
    The Minister's oversight powers should be reduced or counter-balanced by another authority, such as Parliament. Mechanisms should be specified beyond the public interview process, defined in Section 13 (3), in order to ensure that appointments are not politically motivated, and there should be an open process of appointment, such as that used for appointing the SARS commissioner.

[2] Samuels F, Amaya A, Pose R, Balabanova D. Pathways to progress: a multi-level approach to strengthening health systems. London: Overseas Develpment Institute; 2014.
[3] Balabanova D, McKee M, Mills A. "Good Health at Low Cost": 25 years on. What makes a successful health system? London: London School of Hygiene & Tropical Medicine; 2011.

Chapter 5: Chief Executive Officer

18. Section 19 (1) indicates that a transparent and competitive process will be undertaken to appoint the CEO. However, Section 19 (2) indicates that the Board, which was appointed by the Minister, will conduct interviews and that the Minister will approve the recommendation of the Board.
    This presents a potential conflict of interest, with the Ministers having excessive influence, and could undermine the autonomy of the CEO. We suggest that this appointment be confirmed at a higher level, either by Parliament or by the Presidency.

Chapter 7: Advisory Committees established by Minister

19. The three advisory committees to be established i.e. the 1) Benefits Advisory Committee, 2) Health Care Benefits Pricing Committee and 3) Stakeholder Advisory Committee, all have vital and inherent implications for the implementation of the Fund and the provision of UHC in the country, and there is a need for transparency around the creation and constitution of them. All these committees are also currently defined as “advisory”, which suggests that they have no actual power to take decisions. That power again lies with the Minister who, according to the Bill, must have a representative on each of the committees.
    The Stakeholder Advisory Committee needs to have a strong, impactful voice; else it will simply become a token structure. Additionally, there needs to be clear definitions of powers, roles and capacities of all committees; in relation to the Board and the Minister.

Chapter 8: General provisions applicable to operation of Fund

20. Section 31 (1) outlines the role of the Minister as being responsible for governance and stewardship of the national health system, as well as governance and stewardship of the Fund. We believe that the latter presents the similar conflict of interest raised previously, in relation to the excessive power and responsibilities placed on the Minister.
    We suggest that the duty of governance and stewardship of the Fund, be assigned to the CEO of the Fund.

21. Section 33 states that once the NHI has been fully implemented, medical schemes may only offer complementary cover for services that are not reimbursable by the Fund. We believe that ultimately, when the health system is in a position to deliver UHC, there will be a diminished role for medical schemes and this clause may become more appropriate. However, during the transition period from the current, through to the transitional system, and finally to the point of optimal coverage of health care services under an NHI-funded system; patients might encounter aspects of suboptimal quality care, e.g. unduly long waiting times, which might impact health outcomes and there might be related litigation risks. Consequently, it would be safer to allow patients and their medical schemes the option of paying for health care that might be needed.
    Thus, we suggest that there not be a restriction on the services that medical schemes are allowed to fund.

22. Related to the above point, attention needs to be paid to the quality of care of services from providers that have not been accredited by the OHSC or by the NHI fund.
    Some considerations would include the need for certification and/or monitoring of all establishments and practitioners, to be able to provide healthcare services irrespective of whether they contract with the NHI fund or not, and related support for the achievement of this end, as well as incentives for contracting with the NHI fund.

23. Section 37 of the Bill makes provision for the establishment of contracting units for primary health care (CUPS), comprised of a district hospital, clinics or community health centres, ward-based outreach teams, and private providers. Inter alia, the role of these units includes identifying accredited public and private health care service providers, and managing contracts entered into with accredited health care service providers. These new structures seem to be the equivalent of the current sub district units, with prescribed levels of care and enhanced health financing competencies. While the CUPs sounds theoretically comprehensive, it is concerning that a new operational model is being introduced into the health system nationally, as part of the Act, without prior proof of concept or contextual feasibility. Of most concern is the varied availability of all prescribed levels of care within different sub-districts in the country, with decreased availability in rural areas. The private health care sector also currently functions without consideration to interdependence, and it is vital that the mechanisms and manners in which private providers will form part of the service delivery platform, within and NHI-funded healthcare system, be articulated before integration can be planned.
    Additionally, we caution against the assumption that contracting mechanisms, however effective, are an appropriate substitute for strong leadership and governance. A key issue in the current system is the prevailing ‘compliance culture’ that prevents the public health system from being responsive to contextual challenges and local communities, and from creatively responding to routine challenges. Replacing compliance-driven regulatory mechanisms with contractual mechanisms is unlikely to resolve, and may exacerbate, this issue, further constricting the capacity of the system to be responsive to shifting population needs.
    We suggest that the introduction of CUPS into the District Health System be reconsidered at this point in time. If, however, this revised organisation of the system is felt or found to be the best model to adopt, we suggest that the structures, capabilities, and capacities of the existing District Health System be considered in relation to the envisaged model. We further suggest that required changes then be planned for with appropriate consideration given to structural investment, capacity development, incremental and realistic timelines for introduction of sequential changes, inclusion of provisions for a responsive, learning health system, and ultimate consideration to the potential of the proposed system to provide for optimal coverage and equity in healthcare provision.

24. We also suggest that provisions be put in place to ensure that relevant contracting units are responsible not only for contracting health care providers, but also have the mandate and resources necessary to engage actors outside the formal health system including community groups, civil society organisations and NGOS, and other government sectors whose actions affect population health. In addition, for effective functioning, the funding of health promotion and prevention should match the support for service provision. This should include working with communities to ensure active community participation and collaborating across sectors to address the social determinants of health.

25. The proposed role of the Provincial departments of Health is not apparent in the Bill. The current National Health Act places the responsibilities for implementation of national health policy, norms and standards at the provincial level, though the NHI Bill might suggest that these functions will be moved to the District and Sub-district level. Section 20 including (2,ii) of the NHI Bill indicates that liaising with the District Health Management Office is a responsibility of the CEO of the NHI Fund. If this is the case, significant structural and functional changes to the current health system are being proposed, which disregards the already established Provincial Health Management systems that are in place.

    We suggest that the structures, capabilities, and capacities of the existing Provincial Health System be considered and that any proposed changes be planned for with appropriate consideration given to structural investment and capacity development required at lower levels, incremental and realistic timelines for introduction of sequential changes, and inclusion of provisions for a responsive, learning health system.

26. Overall, the lack of clarity surrounding the envisaged service delivery platform needs to be addressed, albeit be via alternate though simultaneous planning and legislative processes, ahead of being able to

decide how these services will be funded. Currently, attention is given to the organisation of services within the public health system. Though, for optimal purchasing within the NHI funded system, the entire health system needs to be considered, including public health care facilities, patient transport systems, referral pathways, private health care facilities, and Non Governmental Organisations. The latter two are especially relevant, given the marked potential for incorporation and coordination with these sectors to address many shortages and gaps within the current Public Health system, and for the inclusive service delivery platform to be able to support the goal of UHC and health equity.

27. The current status of the South African healthcare system does not offer the quality and equality of healthcare service provision, as envisioned in an NHI-funded health care system. It is concerning that approximately one percent of the 696 public health establishments assessed by the Office of Health Standards Compliance (OHSC) were judged to meet the standards for accreditation in the latest report issued[4]. There is consequent concern that the accreditation process will render the majority of public sector facilities ineligible to be contracted by the NHI fund, therefore resulting in a heavily private sector dependent delivery model. Accreditation by the OHSC introduces the risk of creating an open market for the private sector, as there is a very real concern that if relatively few public facilities achieve accreditation, the NHI would result in de facto privatisation of the public health system.
    The implications of this need to be considered and related regulatory mechanisms should be developed to avoid cost escalation in circumstances where private providers are competing against other private providers for contracts. Relatedly, the Bill provide should clarity on what would happen to public facilities that do not achieve accreditation and measures to strengthen the public sector capacity to meet accreditation standards.

Chapter 10: Financial Matters

28. This Chapter outlines the revenue sources for the Fund, auditing by the Auditor General and processes for submitting annual reports to Parliament. There are concerns related to the sustainability of sources of funding and the critical need to maximise efficiency of the system through proper governance and risk management at all levels, and in both public and private sectors. Strict controls for prevention of corruption and elimination of wasteful expenditure need to be considered throughout the system.

29. Given the current context, there is also an urgent requirement to safeguard the funding pool against litigation. South Africa's health litigation bill is spiralling out of control[5]. South Africa's nine provincial health departments faced a R24 billion patient litigation bill[6] between 2010 - 2014, of which only R500 million has been paid. Medical litigation history in South Africa illustrated that there was little defence if a healthcare worker did not follow protocols. In many instances records are only retained for five years and cases coming to court after this period are indefensible, because the records have been destroyed. To compound this, there is very little incentive for the professionals concerned, for in general terms, the liabilities rest with the State rather than the professionals concerned. It has be anticipated there is a very serious threat to depletion of funds available within the NHI fund, in a manner that cannot be budgeted for or anticipated. The reality is that the NHI fund, in pooling all available funds, is potentially also lining the country up for exponentially escalating legal claims. The litigation industry has shown

[4] Office of Health Standards Compliance. Annual Inspection Report 2016/17. 2018.

[5] Bateman C. Counting the public healthcare litigation bill. S Afr Med J 2016;106(11):1063-1064. DOI:10.7196/SAMJ.2016.v106i11.12059 http://www.scielo.org.za/scielo.php?script=sci_serial&pid=0256-9574&lng=en&nrm=iso – 2Oct19

[6] Topping the accumulated litigation claims charts from 2010 to 2014 was Johannesburg, Gauteng Province (ZAR14 019 billion). It was followed by Durban, KwaZulu-Natal (ZAR5 477 billion) and Mthatha, East London and Port Elizabeth in the Eastern Cape (total ZAR3.53 billion). Bloemfontein in the Free State was ranked fourth at ZAR780 million, while Cape Town in the Western Cape lay fifth at ZAR562 million. The province with the lowest litigation costs was the Northern Cape (Kimberley), at a 'mere' ZAR47.83 million.

itself to be very adept at exploiting this weakness, as been demonstrated with the road accident fund, and the system that allows prosecuting lawyers to take a significant cut of any pay out – doubling their hourly rate to take up to a maximum of 25% of the pay out, when they win their case.

Thus, the NHI Bill must include a "no fault" compensation provision in the Bill, which will ensure for the fair recompense to those injured during the care process, and thereby limit the liability of the fund to legal claims in a similar way as Road Accident Fund Amendment Act 19 of 2005 provided for the no-fault payment of compensation for loss or damage wrongfully caused by the driving of motor vehicles. This is far better than leaving the process up to the results of litigation based on the principle of "tort", roughly the notion of the finding of individual fault in a court of law. Several "no fault" compensation systems with different characteristics operate internationally in Denmark, Sweden, Finland, and New Zealand, which seem to offer far more progressive ways of dealing with the compensation of individuals who have been injured (whether negligently or not) without the need to involve expensive litigation. An optimal compensation system should compensate injuries when they occur, but also reduce errors and harm. The tort system used in most countries is increasingly anachronistic and an obstacle to progress on patient safety. A "no fault" system of compensation such as that used in New Zealand may result in better quality of care[7].

Chapter 11: Miscellaneous

30. The Bill is silent on the implementation of the Fund. The NHI Implementation Unit has been established, and mechanisms for feedback and learning should be legislated. Importantly, this can't all happen at national level and must allow for bottom-up learning that supports further implementation. The phasing in of NHI does not consider how to develop system capability through implementation, monitoring, and responsiveness over time. It takes a top down approach, which does not allow for potential gaps to be detected and proactively addressed.
    It would be optimal to clarify some of these basic principles for implementation in the Bill e.g. goals to work towards, support for experimentation, the need for monitoring and learning, and resources for capability development, ahead of implementation steps.

    Additionally, there should be dedicated funding to support learning for implementation/capability development, that would involve commissioning and tendering outside the usual government procurement processes and that would require shared priority setting between government and research actors. A bottom up process should be proposed, where the phasing in of changes actually support and enable system capability. For example, phase 1 could include plans for how to implement the next steps and develop system capability, and how to support this, including setting up evaluation/learning processes. Phase 2 could include waves of implementation at district level, based on district performance against specified outcomes/goals and linked to greater delegation of authority - only when performance is adequate against outcomes/goals would further delegation be made. A specific body (or several at sub-national level) and process could be identified to support districts to develop capacity to manage delegations, which should also be linked to learning/evaluation work.

[7] P Davis R Lay-Yee R Briant A Scott. Preventable in-hospital medical injury under the "no fault" system in New Zealand. BMJ Quality & Safety 2003; 12 251-256 Published Online First: 01 Aug 2003. doi: 10.1136/qhc.12.4.251

OTHER COMMENTS

Softening use of commercial, business and health insurance language

31. The Bill uses language that is more orientated to private sector concepts, commence, business and health insurance than the provision of UHC in a compassionate way. The macro-economic paradigm it appears to favour is a market-oriented, neoliberal approach. The alternative more progressive approach recognises that a strictly market approach needs to be reframed into a more multisector approach that emphasizes a more developmental macro-economic perspective.

    The Bill should phrase its health financing arrangements in a more progressive way and should for example, align itself with international approaches such as the Addis Ababa Action Agenda (2015)[8] and follow its guidance in regard to a transition towards sustainable financing through domestic public resource mobilization. It should scale up efforts to set and reach nationally appropriate spending targets for investments in health consistent with national development strategies and in accordance with the above, in particular to follow-up on commitments and assess the progress made in the implementation of the 2002 Monterrey Consensus[9] and the 2008 Doha Declaration[10]. The Addis Agenda includes a follow-up global financing strengthening process, including an annual ECOSOC[11] Forum on Financing for Development, the creation of an Inter-agency Task Force on Financing for Development, which reports annually on progress and the means of implementation of the 2030 Agenda for Sustainable Development. Three important dimensions of the Addis Agenda are inclusive economic growth, protecting the environment and promoting social inclusion. It provides a global framework that seeks to align financing flows and policies with economic, social, and environmental priorities. Expanding on the previous Financing for Development outcomes, it includes seven Action Areas:

    Seven Action Areas on Financing for Development

    1. Domestic public resources
    2. Domestic and international private business and finance
    3. International development cooperation
    4. International trade as an engine for development
    5. Debt and debt sustainability
    6. Addressing systemic issues
    7. Science, technology, innovation, and capacity building

[8] Addis Ababa Action Agenda of the Third International Conference on Financing for Development (Addis Ababa Action Agenda)Sixty-ninth session. Agenda item 18, 15-12674 (E) Resolution adopted by the United Nations General Assembly on 27 July 2015 [without reference to a Main Committee (A/69/L.82)] 69/313.

[9] The Monterrey Consensus was the outcome of the 2002 Monterrey Conference, the United Nations International Conference on Financing for Development in Monterrey, Mexico. It was adopted by Heads of State and Government on 22 March 2002. Over fifty Heads of State and two hundred Ministers of Finance, Foreign Affairs, Development and Trade participated in the event. Governments were joined by the Heads of the United Nations, the International Monetary Fund (IMF), the World Bank and the World Trade Organization (WTO), prominent business and civil society leaders and other stakeholders. New development aid commitments from the United States and the European Union and other countries were made at the conference. Countries also reached agreements on other issues, including debt relief, fighting corruption, and policy coherence.

[10] The Doha Declaration on the TRIPS Agreement and Public Health was adopted by the WTO Ministerial Conference of 2001 in Doha on November 14, 2001. It reaffirmed flexibility of TRIPS member states in circumventing patent rights for better access to essential medicines. In Paragraphs 4 to 6 of the Doha Declaration, governments agreed that: "4. The TRIPS Agreement does not and should not prevent Members from taking measures to protect public health. Accordingly, while reiterating our commitment to the TRIPS Agreement, we affirm that the Agreement can and should be interpreted and implemented in a manner supportive of WTO Members' right to protect public health and, in particular, to promote access to medicines for all."

[11] The United Nations Economic and Social Council (ECOSOC) is one of the six principal organs of the United Nations, responsible for coordinating the economic and social fields of the organisation, specifically in regards to the 15 specialised agencies, the eight functional commissions and the five regional commissions under its jurisdiction.

Enhancing the role of PHC in strengthening UHC

32. The definition of "primary health care" defined in the Bill is not in keeping with international usage. It defines *''primary health care'' as a means addressing the main health problems in the community through providing promotive, preventive, curative and rehabilitative services and indicates that it is (a) the first level of contact of individuals, the family and community with the national health system, bringing health care as close as possible to where people live and work, and constitutes the first element of a continuing health care process; and national health system, bringing health care as close as possible to where people live and work, and constitutes the first element of a continuing health care process; and (b) in the public health sector, is the clinic, and in the private health sector, is the general practitioner, primary care nursing professional, primary care dental professional and primary allied health professional, through multi-disciplinary practices.* A more appropriate description of this type of care is "primary medical care" or "essential health care," not primary health care

    The definition of primary health care in the Bill should be included alongside the definition of primary medical care and be in keeping with the international usage. Convening on the fortieth anniversary of Alma-Ata (1978), the Declaration of Astana (2018) [12] reaffirmed the commitment to all PHC's values and principles, as defined at Alma Ata, in particular to justice and solidarity, underlining its importance not only for health, but for peace, security and socioeconomic development, emphasizing their interdependence. In narrowing the definition of PHC to a level of care, the definition in the Bill has failed to recognize that primary health care is not a point of care, but an inclusive, effective and efficient approach to enhance people's physical and mental health, as well as social well-being. Using the original principles of PHC as contained in the Alma Ata Declaration , the Declaration of Astana has described PHC as a cornerstone of a sustainable health system for UHC and the health-related Sustainable Development Goals (SDGs). The Bill should change its definition of primary health care, in line with the current cohesive WHO definition based on three components: (a) meeting people's health needs through comprehensive promotive, protective, preventive, curative, rehabilitative, and palliative care throughout the life course, strategically prioritizing key health care services aimed at individuals and families through primary care and the population through public health functions as the central elements of integrated health services; (b) systematically addressing the broader determinants of health (including social, economic, environmental, as well as people's characteristics and behaviours) through evidence-informed public policies and actions across all sectors; and (c) empowering individuals, families, and communities to optimize their health, as advocates for policies that promote and protect health and well-being, as co-developers of health and social services, and as self-carers and care-givers to others. The Bill should expand the delivery of and prioritize investments in primary health care as the cornerstone of a sustainable health system and the foundation for achieving universal health coverage, while strengthening an integrated and effective referral system for secondary and tertiary care;

Avoiding over-medicalisation: balancing personal & non-personal care services

33. The approach to health care in the NHI is based almost exclusively on the provision of personal health services. It is focussed on provision of services in clinics, GP practices and hospitals. While clinical service provision is undoubtedly an important aspect of health improvement, as will be argued in the following sections, non-personal services, which cannot be costed in the same way as the personal health services, are crucial to improve health outcomes. The risk of this approach is the spiralling costs of clinical health care provision and missing out on the considerable cost savings of taking a more preventative approach.

[12] WHO, UNICEF. Declaration of Astana. Global Conference on Primary Health Care From Alma-Ata towards universal health coverage and the Sustainable Development Goals. Astana: WHO and UNICEF, 2018. https://www.who.int/docs/default-source/primary-health/declaration/gcphc-declaration.pdf (accessed June 28, 2019).

The Bill would be greatly enhanced if the mechanism made provision for the financing of non-personal health services as well, for example health promotion. The term UHC would be a far better description for the goal of the Bill rather than the current NHI.

Acknowledging the crucial importance of health promotion

34. The Bill is essentially silent on the financing of health promotion. The language in the Bill is currently quiet about the need for effective health information provision. It is widely acknowledged that taking measures to promote active and healthy lifestyle, including physical activity in the entire population and for all ages is one of the most cost-beneficial areas for health intervention. The same can be said for food security and health eating. As well as ensuring a world free from malnutrition in all its forms, nutrition is crucial to deal effectively with nutrition to stem the escalating the burden of chronic disease such as obesity, diabetes, heart disease, cancer etc.

    Health Promotion is critical for the success and sustainability of the Fund and for the provisions for UHC in the country, thus this requires political and legislative recognition. Additionally, the NHI Bill will provide a framework for funding prioritisation, thus it is imperative that this essential aspect of the package of health services be acknowledge at this stage. The Bill should prioritize health promotion and disease prevention for example stressing mechanisms to support all people having access to adequate food and enjoying diversified, balanced and healthy diets throughout their lives, with special emphasis on breastfeeding and protection of children in their first 1,000 days. On these and similar issues regarding health literacy and education, as well as programmes to develop safe and healthy cities, enabling people to have increased knowledge and control over their health decisions. The financing of this needs likewise to be catered for. It needs to provide for example for the scaling up efforts to address the growing burden of deaths and injuries related to road traffic, drowning, and mental health, and to take measures to promote and improve mental health services and care.

Acknowledging the social, economic and environmental determinants of health

35. Social determinants of health include the recognition that a huge array of social, economic and environmental factors impact on the health of people and magnify or diminish the costs of illness. As it stands at the moment, the Bill does not recognise this at all.

    The Bill should recognize that a large number of factors beyond personal health services affect the health outcomes of a nation. For example, adequate and sufficient nutritious food as well as sustainable, resilient and diverse nutrition-sensitive agriculture and food distribution systems are vital for healthier populations. Furthermore the Bill needs to recognize the impact of many other important and urgent challenges to the health system. Critical examples included climate change and the impact of environmental degradation on the clean air and safe drinking water. Numerous other issues impact profoundly on health, such as decent work, sanitation, secure shelter, education, safe transport, social safety nets, and so on, all of which are needed to promote and protect people's health. Adequate provision for the basic needs of the population should be the foundation of a resilient, people-centered universal health care system, which is necessary to protect all people and, in particular vulnerable communities and individuals, including those living in rural or underserved areas. The Bill needs to unequivocally acknowledge the importance of such social determinants in its preamble, expressing concern for the people living in fragile settings where protracted humanitarian crises, and health and other emergencies, including armed conflicts, challenge national systems capacities and the provision of essential health services, and stress the urgent need for a more coherent and inclusive approach to strengthen health systems and health security. It implies that health services must work in an intersectoral manner.

Coherent and coordinated action across sectors and actors

36. A key aspect of PHC is its call for intersectional and multisectoral action: the importance of pursuing whole-of government and whole-of-society approaches, as well as health-in-all-policies approaches, equity-based approaches and life-course approaches. A fundamental tenet of the PHC approach is addressing the social determinants of health through inter-sectoral action, and facilitating individual and collective community participation in healthcare planning and implementation. While the 2017 NHI policy document states that "NHI aims to transform delivery of healthcare services by focussing on health promotion, disease prevention and empowered communities", the current Bill reflects a bio-medical model of health care, and does not consider the inter-sectoral actions necessary to support health promotion and address the social determinants of health.
    The Bill should provide for strategic leadership on UHC at the highest political level and promote greater policy coherence and coordinated actions through whole-of-government and health-in-all-policies approaches, and forge coordinated and integrated whole-of-society and multi-sectoral response, while ensuring to align support from all stakeholders to national health policies.

Broadening the Population health perspective

37. There has been an inadequate recognition of the role of population/community/public health medicine in the Bill. This could be disastrous and costly to the health system.

    Public health professionals, including the discipline of Public Health Medicine (PHM), are a vital resource to assist in the delivery of UHC and need to be recognised as such. While these skills sets are acknowledged in the last Human Resources for Health policy in South Africa, which specified that the role of PHM Specialists and other Public Health graduates in management and strategy should be more explicit, and that the Department should work with universities and the College of Medicine of South Africa to develop related competency and jobs frameworks. However, this has not yet translated into career paths for Public Health professionals and PHM specialists[13]. The latter is a field that was created specifically to meet the population health demands of the health system, with graduates having a prior medical training and being certified as competent with regard to preventative medicine, health management, strategic planning, monitoring and evaluation, health financing, policymaking, research, and leadership skills. This experience and expertise, in one cadre of human resource, has immense potential to impact the health system and population health if situated appropriately within the health system, which should be a significant consideration during planning for the NHI fund and UHC.

Public Health Surveillance

38. Public health surveillance is the continuous, systematic collection, analysis and interpretation of health-related data needed for the planning, implementation, and evaluation of public health practice. Such surveillance can: serve as an early warning system for impending public health emergencies; document the impact of an intervention, or track progress towards specified goals; and monitor and clarify the epidemiology of health problems, to allow priorities to be set and to inform public health policy and strategies. Failure to anticipate such problems could prove disastrous to the health system

    The Bill should provide for strengthening surveillance systems and routine vaccination capacities to prevent spread and/or re-emergence of communicable and non-communicable diseases.

[13] Zweigenthal, V., London, L., & Pick, W. (2016). The contribution of specialist training programmes to the development of a public health workforce in South Africa. South African Health Review, 2016(1), 45-59.

Occupational health

39. Occupational health is another arena which provides an example of where non personal services are import. Occupational health deals with all aspects of health and safety in the workplace and has a strong focus on primary prevention of hazards. The health of the workers has several determinants, including risk factors at the workplace leading to cancers, accidents, musculoskeletal diseases, respiratory diseases, hearing loss, circulatory diseases, stress related disorders and communicable diseases and others. Employment and working conditions in the formal or informal economy embrace other important determinants, including, working hours, salary, workplace policies concerning maternity leave, health promotion and protection provisions, etc.

    The Bill should provide finance for the scaling up efforts to provide healthier and safer workplaces and access to occupational health services, and to ensure health coverage for all workers, noting that large numbers of people who develop illnesses and die every year from preventable occupational diseases and injuries.

Strengthening the participatory approach and institutional governance

40. Community participation – the recognition that people's engagement and the inclusion of all stakeholders as a core component of PHC and effective health system governance is essential to fully empower the people of a nation to improve and protect their own health. Community participation is therefore an essential building block contributing to the achievement of UHC

    The Bill should emphasise the need to engage with all relevant stakeholders, including the civil society, private sector, philanthropic foundations, academic institutions as well as the community through the establishment of participatory governance platforms and multi-stakeholder partnerships, in the development and implementation of health- and social-related policies and progress monitoring to the achievement of national objectives for UHC, while giving due regard to managing conflicts of interest. The Bill should further provide for financial support to strengthen the capacity of national government authorities to exercise strategic leadership and strengthen the capacity of local authorities to engage with their respective communities. It should create mechanisms to build effective, accountable and inclusive institutions at all levels to ensure social justice, rule of law, and health for all. As a means of providing the regulatory and legislative framework for the achievement of UHC, the Bill should ensure access to health services, products and vaccines as well as to provide funding to assure the quality and safety of services, products and practice of health workers.

Promoting the use of technologies, innovation and data

41. The Bill is relatively silent on the use of technology for innovation and digital data.
    The Bill needs to provide for investment in and encouragement of ethical and public-health-driven use of appropriate and user-friendly relevant technologies, including digital technologies (eHealth), mobile technology (mHealth) and innovation to increase access to health, social services and related information. This is necessary to improve the cost-effectiveness of health systems and efficiency in the provision and delivery of care, while recognizing the need for an integrated health information system for public health surveillance and the need to narrow the digital divide. It is important to strengthen national capacity on health intervention, technology assessment and data collection to achieve evidence-based decisions. It is important to collect data, including vital statistics, disaggregated by age, sex, income, disability, geographic location, status, education and other social characteristics needed to monitor progress and identify gaps in the universal and inclusive achievement of SDG3 and all other health-related SDGs.

CONCLUSION

42. Section 21 (2) of the National Health Act sets out the roles of the Department within the national health system. These roles include: guidance and oversight related to norms and standards on health matters, including: the provision of health services related to social, physical and mental health care, management of communicable and non communicable diseases, promotion of health and healthy lifestyles, participation in intersectoral and interdepartmental collaboration, promotion of community participation in the planning, promotion of norms and standards for the training on human resources for health, provision and evaluation of health services, and health systems research in the planning, evaluation and management of health services, nutritional intervention, and hazardous environmental conditions.

43. Consequently, it would be important for health financing at the national level to provide funding so that all these fundamental aspects of health care provision are provided for, and this should be central to provisions in the NHI Bill.

44. The NHI represents a momentous social engineering experiment in South Africa, the impact of which can be transformative for the goal of UHC and for improved prosperity in the country at large. Thus, care needs to be taken to institute changes that have the best possibilities of success, in an incremental manner, and employing the best possible evidence-based policymaking.

45. Finally, we suggest that thought be given to a comprehensive NHI communication strategy, as communication is crucial to achieve buy-in from citizens and health care workers, build public trust in the policy process, and instil a sense of common purpose in all.