



*Health for All Now!*

**People's Health Movement**

**South Africa**

## **Comment on the National Health Insurance White Paper**

**Submission by the People's Health Movement of South Africa**

**31 May 2016**

### **Preamble**

The ideas in this submission emerge from workshops, consultations and programmes run by the People's Health Movement of South Africa (PHMSA) over the past two years and particularly in the past 6 months with communities in the Western Cape, Eastern Cape, KwaZulu-Natal, Gauteng, North West Province, Northern Cape, Mpumalanga and Free State, in collaboration with Civil Society partners. We also acknowledge having drawn on a paper developed for the Foundation for Human Rights on the NHI by Leslie London, and on submissions developed by our Civil Society partners, including Women on Farms Project, Cape Metropolitan Health Care Forum and Rural Health Advocacy Project.

### **Introduction**

PHMSA welcomes the long awaited release of the White Paper policy document on the National Health Insurance for South Africa, anticipated since early 2012. Health workers, communities, grassroots activists and social movements have been asking for details about the NHI policy process which has mainly taken place behind the closed doors of the ministerial appointed cabinet committee bound by confidentiality and with no interaction with broader society. The delay in the release of the White Paper has effectively put us back several years in implementing urgently needed change in the health sector.

We would like to acknowledge and support all the principles stated as underpinning the NHI plan, and in particular:

- A recognition that the health systems, both private and public, are in crisis and that significant change is required.
- A commitment that the health system should be built on the premise of the right to health for all and the principles of quality and equity in health.
- The affirmation of the importance of social solidarity – we have to stand together for a greater collective benefit.
- An unequivocal commitment to health care as a Public Good. As PHMSA we strongly oppose opponents of the NHI plan whose main aim is to maintain the status quo in health care in South Africa and ensure that a two tier system of privilege for the rich and dysfunctional poor quality health for the poor is maintained. We also note that the NHI plan has been significantly challenged by the powerful private health sector industry in South Africa.

## **THE POSITIVE ASPECTS OF THE WHITE PAPER**

### **We welcome the following:**

1. The guiding principles stated in the NHI White Paper, including the principles of social solidarity, the right to health, equity and affordability.
2. The aim to mobilise additional resources for health through the implementation of a “health tax” which will be mandatory. Also, the aim to ensure universal access through purchasing reforms which, implemented over time, could ultimately blur distinctions between public and private providers.
3. The stated emphasis on primary health care, as well as practical strategies to implement this, outlined in Re-engineering Primary Health Care including School-based Primary Health Care teams, Municipal Ward-based Primary Health Care teams and District Clinical Specialists.

4. The confirmation that user fees at public health institutions will be abolished. This was ambiguous in the Green Paper and had now been made clear. This a significant step towards decreasing out of pocket and point of service payments which result in the late presentation of clinical problems with consequent poor patient outcomes and the increased cost of more complex management.

5. The clarity that the NHI will be a single payer rather than multiple payer system. This is important as a single payer is essential to give the NHI the anticipated leverage to influence health services in both public and private sectors. We know that in other health systems around the world, multiple payer arrangements have been associated with curtailment in access, poor control of costs and increased inequity in health outcomes, to the disadvantage of the poorest needing care.

However, we have a number of concerns regarding the White Paper. These are outlined below.

### **1. Health Facility Accreditation**

The NHI proposal has at its core the idea that health funding which currently goes through the Department of Health and from there to provinces and districts, will now all be pooled in one fund, the National Health Insurance Fund. Facilities, both public and private, will contract in with the NHI fund as health service providers. In order for them to be eligible, the facilities would need to pass an accreditation process managed by the Office of Health Standards Compliance. An audit done from 2011 – 2012 by the Health Systems Trust (commissioned by the Department of Health) showed that collectively public health facilities scored <50% on 2/6 priority areas of the National Core Standards (NCS). 48 public facilities had no water available on the day of the audit and 35 public facilities had no electricity on the day of the audit.

From these results and from anecdotal evidence, it appears that public facilities in their current state will struggle to meet the necessary standards for accreditation. While there

may be an assumption that part of the NHI plan is to upgrade these facilities, *there is no stated commitment to this in the White Paper policy document*. Importantly, there is no budgetary allocation to support the infrastructure and human resources expenditure that are critical to ensure that these facilities are upgraded. Hence, we have a concern that private sector facilities are more likely to pass the NCS and therefore to be accredited by NHI. Without a stated commitment to improving public facilities, the accreditation process becomes a punitive and exclusionary one which disadvantages the public sector and privileges the private sector.

The White Paper states that users will need to access health facilities closest to where they stay. However, it is also well-recognised that the poorest districts of the country, often with the worst health outcomes and the poorest services in the country, are the least likely to achieve accreditation with the Office of Standards Compliance (Paragraph 219) without massive investment of state resources to build up these public facilities. These are also areas where there is a dearth of private facilities. Thus, it is the poorest and most vulnerable populations who are dependent on public sector services in areas where private sector services are not available at all, or only in the most basic form (e.g. private practices). Coupled with the penalties for using services outside of your residential area, this situation risks aggravating inequities in access to health care. In that sense, the White Paper fails to meet its own description of UHC (Paragraph 52(i)) where it is argued that “The right to access quality health services will be on the basis of need and not socioeconomic status.” Without attending to the inherent bias in the simplistic use of accreditation to count facilities in or out, the policy risks aggravating lack of access in areas where it is already poor.

The rallying cry of the NHI is that everyone will be able to access better health care as they will be able to use both private and public sectors. This is certainly how many community members and citizens are interpreting the key benefit of the plan. However, for the majority of the rural population and for the urban poor, for whom there are no private facilities in their direct vicinity, the perceived benefits of the NHI will be a chimera.

## **2. Service Coverage (Package of Care)**

According to the White Paper, the NHI will provide a comprehensive package of health care. An NHI Benefits Advisory Committee will be established to decide on "Necessary evidence based services and their positive impact on population health". However, it is not clear how this advisory committee will be established or what their accountability will be. This is critical as the White Paper also states that: "However, it is necessary to take into account the reality that irrespective of how comprehensive the NHI entitlements will be, some personal health services will not be covered. This may be as a result of these services not fitting into the mainstream of medically necessary and efficacy-proven interventions approved by NHI (paragraph 400).", and "Services not covered by NHI must be paid for in full." (paragraph 149)

We note that the NHI will exclude certain services such as purely cosmetic procedures or interventions with little proven benefit. This is to be expected. However, we as PHMSA are more concerned about the way in which general decisions about rationing will take place in an NHI. The concept of 'comprehensive' lends itself to a very wide range of interpretation. We have seen this problem played out in the private medical industry with medical aid schemes excluding many aspects of medical care. The key issue is, how will the NHI decide what interventions and services will be supported? What is the process by which the package will be determined, what are the criteria that will be used and who will make these critical decisions? In balancing criteria, what importance will be attached to equity relative to cost-effectiveness? How will ordinary people participate in such decisions? This is not clarified anywhere in the White Paper. Indeed, there are many instances of vested interests in private health care trying to influence what is included and what is not included in the package of 'comprehensive care' so we are concerned that, in the absence of such clarity, there is a risk that vested interests will capture the process in name of technocratic efficiency.

As PHMSA we believe that the process must be democratic, inclusive and transparent. It should be a broad based consultative process including clinical experts as well as communities and all democratic structures of public participation such as trade unions,

social movements, health committees, community forums and associations. A mass consultation process on what we want in our health system is an opportunity to raise health awareness and empower health decision-making, and is an essential feature of a health system premised on the right to health. The nature of health services will necessitate a strong expert clinical presence in this process but communities have a critical contribution to make too. Importantly, the Benefits Advisory Committee must not follow the process of closed door discussions by appointed committees as we have seen in the development of the White Paper.

We further flag as a concern the use of the phrase "benefits package", which is taken directly from the private medical industry, as such it conjures up the experience of thousands of citizens whose health care needs are not adequately met. If treatments outside the "package of care" are to be paid for by individuals and the care package is not truly comprehensive, it will undermine the principle of free health care at the point of service and may be a way that "co-payments" (which the White Paper explicitly commits to eradicating) will slip in through the back door.

Lastly, we emphasise that access to health care is not merely dependent on what goes into the "benefits package" but what the NHI does about removing obstacles to access. About 40% of South Africans report health facilities beyond walking distance and about 30% of South Africans reported either difficulties in obtaining care they needed, or having foregone medical care in the past year as a result of difficulties in access (1). For marginalised populations, transport to health facilities remains a significant barrier. Farm workers and rural populations lack the means to get to health facilities, and research has shown that even for free health services such as TB, antenatal care and ARV services, the costs of transport remain a major barrier to access (2). For farm workers, their precarious position as residents on the farm owner's private property restricts their autonomy to reach services in nearby towns, since many farm owners remain unsympathetic to their workers' health needs. We believe the NHI has to do more about securing access for vulnerable populations if it is to realise the objective of Universal Access. For example, it should include the capacity to pay or arrange patient transport for certain groups disadvantaged by rurality or employment relationships that undermine access to health care.

### 3. Migrants and Foreign Nationals

The way migrants and refugees are treated in the NHI White Paper is potentially problematic. It sets up a clear distinction between migrants with status, migrants who have applied for status, and undocumented migrants. This is a legal distinction, but not one which justifies differential access to health care. The White Paper contradicts itself in a number of places on this matter. For example, paragraph 106 states clearly that the NHI is intent on “ensuring progressive realisation of the right to health by extending coverage of health benefits to **the entire population...**” whereas in the very next paragraph 107, the White Paper commits only to providing “universal health coverage for all South Africans.” The commitment to the “entire population” rather than to citizens/residents only is repeated again in paragraph 321 where the NHI Fund is described as using “monopsony power to strategically purchase services that will benefit the entire population.” If migrants are not entitled to universal health coverage, then they will not benefit from the NHI monopsony power.

The White Paper thus appears to set up two-tier system with one set of benefits for South Africans and a lower level of benefits, framed as ‘basic health services’ for documented migrants with refugee status, following the language of the Refugees Act (Section 27.g). Setting up different packages of care appears to contradict the very basis of Universal Access. A further contradiction is that the White Paper states that asylum seekers would be entitled to emergency care (paragraph 122), but that undocumented migrants would have to pay for their emergency care (paragraph 123). Since the Bill of Rights frames access to emergency care 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 appears to be 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 White Paper as a basis for estimating the costs of providing benefits for refugees or proposing any basis for a decision on access based on costs the country can afford. Rather,

the White Paper appears to adopt a narrow legalist approach to entitlements that is neither humane, nor consistent with a human rights-based approach.

If the White Paper is setting out a basis for a limitation of the rights of migrants who are not legally resident in South Africa, it must do so in accordance with section 36 of the Constitution, which speaks to the need for any limitations on rights to be seen to be reasonable and justifiable in an open and democratic society based on human dignity, equality and freedom. This requires the state to present evidence. We believe the White Paper fails in this regard, since it is highly discriminatory. Moreover, it is also arbitrary and impractical. For example, providing access to an asylum seeker for their HIV treatment but not their diabetes (which may or may not be the result of the medication they are receiving) is unethical. Further, when the patient with diabetes suffers a stroke, he or she will be treated as an emergency and resuscitated, but then, once recovered, left without access to treatment. This is neither humane nor an efficient use of health care resources, since an admission for stroke, an entirely preventable condition, is far more expensive than treating the diabetes in the first place. Similarly, if a non-South African refugee with TB related to their HIV seeks TB treatment, do we deny care for their HIV status? Apart from the refugee's own health, s/he poses an infection risk to any contacts. On all counts, the distinction between legal migrants and others appears unsupportable, not only from a rights perspective, but from an epidemiological and operational view.

Further, the White Paper implies that the health services to be afforded to migrants with legal status will not be equivalent to South Africans and permanent residents because they will be provided with "basic health coverage" (paragraph 121) 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 this discussion seeks to establish exceptional status for legal migrants with reduced coverage – which would appear to be in violation of Section 27(g) and our international human rights commitments with regard to refugees.

The government has a right to ration services based on the constitutional mandate to progressively realise social rights within available resources. However, the principles that inform rationing have to be rational, i.e. the means should not contradict the ends. It is



irrational to ration services based on citizenship/immigration status rather than need. If the purpose of the NHI is to improve population health, this can only be achieved by allocating services based on need, not immigration status. This is particularly important in the case of communicable diseases.

#### **4. Addressing the Social Determinants of Health**

While the White Paper on the NHI purports to emphasise prevention and claims that Primary Health Care will be the “heartbeat of the NHI”, it is actually completely silent on the need for and the mechanisms with which to address the social determinants of health. This is a major flaw, as failure to address upstream contributors to ill health will result in an unaltered burden of disease with the emphasis of the health system placed heavily on curative services. A policy for a new health system cannot leave out a discussion on the major contributors to South Africa’s burden of disease. These include the well-recognised problems of poverty, unemployment, poor housing, lack of access to safe drinking water, food and adequate sanitation. But also the less recognised problems such as:

- alcohol use which is the most widespread drug of abuse and third biggest contributor to death and disability in South Africa.
- obesity which is a growing epidemic significantly resulting from the food industry’s promotion of processed, high sugar foods and is itself linked to the increase of diabetes and hypertension.
- outdoor and indoor pollution resulting from wood and coal fires as well as industrial and vehicle emissions exacerbating IHD, COAD, lung cancer and lung disease in children under five.

The lack of programmatic attention to prevention is reinforced in the institutional arrangements (or lack thereof) for prevention. The only mention of any structure to ensure multi-sectoral collaboration to address “diseases of lifestyle” is made in paragraph 190 which talks to the establishment of a National Health Commission drawing together stakeholders from government and non-governmental sectors. This is confusing as the White Paper also talks about a NHI Commission (paragraph 327) which will provide oversight over the NHI. It is unclear if this is meant to be the same structure allowing for multisectoral

collaboration to address diseases of lifestyle. However, it is unlikely that this structure could be both an accountability structure and an advisory structure for prevention. If that is the case, then there is no obvious articulation between the NHI itself and this National Health Commission or how the National Health Commission can influence the workings of the NHI. Further, since “diseases of lifestyle” are mostly diseases related to upstream determinants (tax, food production and distribution practices, marketing, advertising, transport policy, etc), one would want to be very sure that such a Commission is free of vested interests.

It is possible that the Department of Health envisages itself remaining responsible for prevention activities. Paragraph 318 states that the Department of Health “will also remain a major provider of services.” What these services are is not stated. However, since District Health Management Offices will remain responsible for non-personal health services (paragraph 187) this suggests that it will be the rump Department of Health left with responsibilities for prevention, while the NHI is primarily curative or preventive screening or immunisation of individual clients. If it is envisaged that the DoH will primarily drive preventive services, the NHI will end up fragmenting a unitary health system and the risk of draining resources away from prevention may be aggravated. It is not clear what this paragraph implies. The primary role of a National Department of Health is to be the steward for a National Health System, whether it provides services directly or not.

Further, the White Paper notes that “...to effectively reduce the burden of disease, requires a transformative and redistributive system as envisioned through the phased implementation of NHI.” (Paragraph 106). But, in fact, given the emphasis on a purchaser provider split and on involving the private sector, it is likely that the NHI will massively emphasise curative services to the detriment of prevention. It is well recognized that most gains in better health outcomes come from upstream preventive interventions, often outside the health sector. Yet there is no ring fencing of funding for upstream prevention interventions, there is no talk of outcomes-based metrics that incorporate disease prevention in the reimbursement mechanisms. Indeed, the principles of the NHI outlined in paragraph 53 to 61 speak only of health care, rather than health or efforts to address the social determinants of health. Even in recognizing the importance of prevention and health promotion in addressing problems of NCDs, risk taking and moral hazard (Paragraph 138), the White Paper does not explain how it will support the implementation of such

programmes. The only comment made about prevention services is a very general statement in paragraph 393(a) dealing with purchasing of services. But given the facility-based focus of the NHI, it is unlikely that prevention will gain much foothold in competing for resources.

## **5. The Cost of NHI**

The White Paper estimated that the funding shortfall for NHI will be 71 billion by 2025. However, it is not clear how this is calculated and whether the many relevant factors have been taken into account.

Firstly, the funding shortfall seems to be calculated as a fairly linear progression of the current health budget to the new estimate. There is no specific capital or human resource allocation to upgrade public facilities in order to meet the National Core Standards. It is clear from the Health Systems Trust research as well as anecdotal experience by users of the public health system, significant revitalisation of hospitals and significant re-staffing of facilities is essential to make NHI accreditation accessible to and attainable for the public institutions most in need. The lack of a capital and HR budget to do this, calls into question whether it will actually be done.

Secondly, the calculation does not take into account the potential impact of preventive and promotive health interventions that should take place. It is assumed that the current burden of disease will go unchecked. This may be planning for the worst case scenario but may also allude to the fact that preventive interventions will not be prioritised in any meaningful way. If prevention were to be properly supported and resourced, we should expect to see a reduction in morbidity and burden on the services; yet this is not reflected in any of the costing models.

Thirdly, the cost of NHI is greatly dependent on the price at which health services will be “purchased” by the NHI fund - specifically on how private sector providers will be remunerated. The current fee-for-service payment system in the private sector has been shown to be ruinously expensive and results in significant over-servicing. While there is a commitment in the White Paper to contracting general practitioners on a capitation basis,

thus far they have been paid on a fee-for-service arrangement. For ambulatory specialists, the plan is to have a "capped case-based fee, adjusted for complexity". Diagnostic services (mainly radiological) will be paid for at a cost for expected volume and if beyond this, on a case-by-case basis. Accredited private pharmacies will be contracted in to order drugs and products and to dispense them at subsidised prices for NHI patients. The pharmacies will then be reimbursed at cost and have a capitated administrative fee.

Finally a capital budget for the construction, equipping and provisioning of facilities in under-served rural and peri-urban areas, seems not to have been provided for within the costing models in the White Paper, except for the mention that some funds for the implementation phase could be acquired from medical aid subsidies and hence presumably some of this income could be spent on capital projects. However, even if this is the intention, the amounts are clearly too meagre for the huge amount of catch-up capital investment required for rural and peri-urban communities to achieve equitable universal access. Additionally, there will obviously be an ongoing need for capital financing both for new facilities in response to population growth and to changing population settlement patterns, as well as for regular maintenance and upkeep of existing facilities and equipment. The White Paper does not provide for these costs.

While throughout the White Paper, reassurances are given that there will be cost containment of provider payments (specifically private providers) and that payments will be equal to those for public providers, the following statement is a telling recognition of the reality:

"393b)i) All public facilities (clinics, community health centres and hospitals) which provide services at a considerably lower cost than private for profit providers should be the backbone of the health system".

BUT a few sentences later:

393biii) "Government will put into place the necessary regulatory and policy interventions to determine tariffs for health services (including provider tariffs and prices for pharmaceuticals and related products). The law will equally apply to public and private providers including suppliers of medicines."

These statements are in contradiction with one another.

Therefore the costs incurred by contracting with private providers with the above systems may well be considerable and unaffordable. The NHI fund is relying on its power as a single large purchaser to influence the pricing level at which private services will be contracted. This is in fact the main motivation for the Fund, yet it is not explained exactly how this leverage will be achieved. The NHI fund will be a public fund with the health budget plus a health tax and, in and of itself, will not have any direct influence on the private sector. The Fund's influence on private sector pricing will be indirect and will depend on the power of monopsony but also on the motivation and ethical conduct of the Fund managers themselves. The process is therefore open to the risk of corrupt collusion and over pricing if proper oversight and audit is not practiced.

For the public sector facilities which are currently financed using global budgets, the NHI proposal advises that these will move to budgeting by Diagnostic Related Groups (DRGs). This means that hospitals will need to submit very accurate information about the number and types of patients, diagnoses and treatments occurring at their facilities. Hospitals will then receive their budgets against this information in direct relation to the services provided. However, information and clerical systems in most public hospitals are weak and struggle to manage their current work load. Budgeting that is dependent on very detailed informatics risks prejudicing against institutions with poor infrastructure and/or may result in an expansion of bureaucratic expenditure at the expense of core clinical service delivery. Payment linked to DRGs has been well researched and evidence suggests that they can result in the incentivising of particular treatments and neglecting of others, especially preventive and promotive services. DRGs additionally have the problems of inflating the level of severity, rapid discharging of patients and frequent re-admissions, all of which are clearly deleterious to patients and greatly increases the cost of service provision.

Although the White Paper makes a commitment to first strengthening the capacity of public sector facilities Information Systems to meet the requirements of DRG-based budgeting envisioned for the NHI, there is no evidence presented in the findings from the Pilot sites that such work has been successful.

NHI should take account of rurality, by means of positive discrimination in funding. As a general principle, financial allocation under an NHI should reflect a commitment to equity. This means that a financial allocation formula must take into account difficult-to-reach populations such as rural populations.

## **6. Mobilising Funds for NHI**

It is noted in the White Paper that R20 billion is spent on state contributions to employee medical schemes and R16 billion is lost on tax credits for private health insurance users. This means that the public sector is subsidising private healthcare to the tune of R36 billion annually (which is more than 20% of the current health budget of approximately R160 billion). According to the White Paper, the R20 billion state contribution to medical schemes is to be phased out in Phase II though it is not clear how this will happen. The R16 billion lost to tax credits will not be touched until after NHI has been implemented. While an argument can be made for slowly phasing out the state employee medical schemes while a substantial improvement in the public health system is actualised, there is no rationale for not doing away with tax incentives for private health insurance. The underlying philosophy for NHI is to shrink, over time, the private health industry and expand the public sector. Removing tax incentives for private insurance must surely then be an early and critical step in this process.

Regarding the new proposed Health Tax, the White Paper still does not give any clarity how this will be mobilised. Five options are given with a mix of the following taxes: VAT, surcharge on income tax, and payroll tax. The NHI is proposed as a progressive health reform. To fund the reform with taxation that is regressive in nature is against the principle of equity so strongly put forward in the proposal. This is particularly critical in South Africa given the extent of current income inequalities – where the richest 10% of the population have 51% of the income and the poorest 10% have 0.2% of the income. An increase in VAT with its current structure, while harnessing funds in the informal sector, is inherently regressive. Unless VAT is significantly restructured, a highly unlikely short term prospect, using VAT will merely increase the burden on the poor who will have to pay for the increased costs of the NHI.

While a regressive tax such as VAT is included in the financing options provided, it is inexplicable why a financial transaction tax, which would be highly progressive, extremely simple to implement, efficient, transparent and buoyant (thus meeting all the tax design principles espoused by the NHI) is not even mentioned in the financing options. Clearly implementing a financial transaction tax should be one of the foremost options for financing the NHI. Similarly, while company tax is briefly mentioned in paragraphs 272, 279 and 282, it is then, again inexplicably, ignored as one of the options for financing the NHI. This seems quite illogical as it also meets all the tax design principles espoused by the NHI. In addition when the NHI takes effect, the contributions that companies would have made to medical schemes to subsidise staff subscriptions falls away and companies will effectively pocket this as profit if some health tax is not instituted to claim these former medical aid contributions for the NHI Fund. Company tax should therefore clearly be one of the means whereby the NHI should be financed.

Indeed the trend in South Africa over at least the past 10 years has been directed away from progressive taxation, resulting in reduced taxation of the highest earners and of corporations. Simply bringing taxation of higher income South Africans (those earning over R700 000 per year) into line with several other countries (including Norway, Japan and the UK ), closing tax loopholes, instituting a low percentage financial transaction tax and a small increase in company tax should provide sufficient funding for the NHI. The options for combinations of these and the effective tax rates required for each of these needs to be costed in detail. However this combination of taxes will ensure sufficient, simple, efficient, progressive, transparent and buoyant (sustainable) financing of the NHI.

The failure to have a clear funding strategy for the NHI plan at this stage of its development implies significant resistance to the real implementation of progressive health reform. Without the basic funding structure in place, the timelines outlined in the White Paper, which end in 2025 with a functional NHI, seem unattainable.

## **7. Emphasising a People Centred Health System**

The NHI proposal does not outline a health system which integrates communities into real decision-making within the health system. Only one paragraph (186) deals with the role of Clinic Committees as vehicles for community participation, despite the commitment to PHC as the heartbeat of the NHI. The National Health Act already establishes Health Committees at all facilities or groups of facilities. However, the current policy hiatus with regard to HCs leaves the determination of their roles and functions to the discretion of provincial legislation. This is problematic for a number of reasons. Firstly, there is wide variability between provinces in their policies on health committees, which is not consistent with a programme intended to enhance universal access to health on a national basis. Secondly, the roles of health committees can vary widely from limited decision-making to playing a meaningful role in oversight and governance. The White Paper skirts over this difference (talking generally about advice, advocacy and public health campaigns).

The exact role recognized for HCs is very important if communities are going to have a say in service they receive. At present, there is considerable reluctance amongst providers and managers to cede power to communities in this context, and many committees simply end up as ‘helpers’ to the overworked staff, rather than exercising any leadership or representing the community in a meaningful way in engaging with the services. Even in paragraph 224, dealing with patient rights and patient-centred care, the paper is silent on the role of HCs promoting patient and community voice. The White Paper could have been much stronger about confirming the importance of meaningful decision-making at district level.

A further problem is the way in which participation is restricted to facility level, in that HCs exercise “participation” only for their facility. However, decision-making in health takes place at district, provincial and national levels. The NHI omits any mention of how to address the insertion of community voice at all levels of the system as has been successfully achieved in other countries, such as Brazil.



## **8. Primary Health Care**

The Re-engineering of PHC has some very positive concrete proposals such as the outline of the Ideal Clinic which all clinics should strive to be. There is also an outline of the Ward Based Outreach (WBOT) teams, School Health Programme and District Clinical Specialist Teams (DCSTs). However, a key weakness is the lack of detail in outlining the role of community health workers (CHW).

A number of 20 000 extra CHW is put forward as a number to be deployed in the poorest municipal wards. However there is no discussion of the significant problems currently faced by CHW, i.e. that CHW are not recognised by the formal public health sector, their qualifications are not standardised nor recognised by any health professional body, they are largely employed informally by NGO's or as part of disease specific community interventions, and that, as a group, CHW are a vulnerable and marginalised workforce. For CHW to be at the centre of primary health care, these problems need to be acknowledged and addressed.

The numbers and ratios of CHWs to be deployed are not specified. There is international evidence that the effectiveness of CHWs depends inter alia on their density (i.e. ratio to population). Coverage of households is critical in ensuring that CHW impact is optimized. Ratios in South Africa will need to be high since our per capita burden of disease is great, with many patients requiring time-consuming home-based care for chronic and disabling conditions. Also, as the National Development Plan has noted, a large number of CHW will not only ensure much improved health care coverage, but will also generate considerable employment, especially for rural women and stimulate the rural economy.

## **9. Human Resources**

The human resource crisis in South Africa is largely a crisis of maldistribution. The majority of health professionals including nurses, doctors, occupational therapists, physiotherapists, psychologists and medical specialists work within the private sector which serves a small

percentage of the population. While the White Paper acknowledges that more nurses and doctors are needed, it does not propose strategies to improve this stark imbalance. Nor is there any concrete plan for how and where extra doctors and nurses will be trained. For example, the statement that nursing colleges should be opened is not supported by information such as which colleges will be opened and when this will happen.

In fact the White Paper as a policy fails to present a concrete, well thought-through and robust human resource plan which begins with the filling of vacant posts in the public sector (last estimated at approximately 30%). Such a plan would also need to include a specific rural human resource plan including strategies such as Rural Medical Schools, opportunities for career advancement in rural areas, changing admission criteria to medical schools to candidates from rural areas, formalised mentoring of (especially rural) staff, and so forth.

*It is impossible for the public health system to deliver quality health care without adequate staffing.*

While training new health professionals is important, a more immediate plan is needed to actively recruit health professionals from the private sector back into the public sector. At present, the opposite is happening with many facilities still reporting that a job resignation at a facility equals a “frozen” post and that vacancies remain unfunded. The public sector human resource bureaucratic processes make appointment of staff slow and laborious and many health professionals are lost to the private sector or emigration in these long delays.

## **10. Conclusion**

It is telling that the White Paper on NHI is released at a time when public health facilities nationally are being subjected to budget constraints and austerity measures. It is not possible to revitalise the public sector and fill staff posts in this context. While the NHI speaks to improving quality and expanding and capacitating the public health sector, those working in the service see the financing of the health system moving in the opposite direction and users see few improvements.

The plan for the NHI spells out the philosophy of a high quality, equitable and publically driven health system. However the process described of accreditation, purchasing of health services from private providers, and the lack of commitment to real funding increases in the public sector are in contradiction with these goals. If the public sector is not significantly and globally upgraded, the NHI poses the very real risk of permitting a net flow of public funds into the private health industry, which will be contracted in to fill the service gap. Also, while some large well-functioning public hospitals may meet accreditation standards, they may become mired in the bureaucratic processes necessary to provide the data to motivate their budgets. In the worst case scenario, in the absence of real public sector upgrading, NHI may inadvertently promote privatisation and exacerbate current public sector inequalities.

As the People's Health Movement of South Africa, we believe that healthcare can only be reliably, appropriately and consistently delivered to the population through the public health system. As stated in the NHI White Paper, we are fully committed to a health system that recognises health as a public good, not a commodity for a market. Therefore, at every step, the NHI plan must strengthen and capacitate the public health system, particularly where it is weak such as in poor urban and rural areas. In practice this means that upgrading and staffing these public facilities must take place first and take place urgently, followed by larger urban facilities, within a coherent and integrated overall plan.

With regard to private sector accreditation, we believe that bringing general practitioners into the public health system through contracting with NHI at the primary care level may have several benefits including supporting struggling municipal clinics and day hospitals. However, bringing in private practitioners should be instrumental to the NHI objective of enhancing universal access, and not be seen as an end in itself. Moreover, trying to provide health care for the population by contracting private hospitals, largely owned by a few very powerful private companies, will be expensive, unsustainable and ultimately undermine the core aim of NHI which is the contraction, not the expansion, of the private medical industry.

A new healthcare plan must also outline in concrete terms how upstream social determinants of health will be addressed both at local and national levels through intersectoral collaboration; it must include communities and health workers at all levels of decision-making and empower community structures such as health committees to have an

integrated role in the health system; it should not discriminate against people on the basis of their nationality or migrant status; it should be adequately funded through a progressive taxation model; and should speak to the recognition and training of large numbers of community health workers as the foundation of a primary health care model.

In addition to the above, in the short term, in this submission we call for an end to budget cuts, austerity measures, and the freezing of posts in the public sector. The Department of Health, in preparation for NHI, should launch a creative and public HR drive to attract health professionals back into the public sector and streamline appointment processes. Our proposal would be to use funds mobilised from the abolition of tax incentives for medical schemes to fund this process. The NHI itself should ideally be financed by a combination of a low percentage financial transaction tax, a small but progressively rising increase in income tax, a small increase in company tax, and the tightening of loopholes currently facilitating tax evasion and tax fraud.

This, together with revitalising public facilities and the launching of a public participation process to inform a comprehensive care package to be delivered by NHI may bring us closer to the ideal of quality universal coverage so eloquently proposed in the NHI introduction.

## References

1. Armah-Attoh D, Selormey E, Houessou R. Despite gains, barriers keep health care high on Africa's priority list. *Afrobarometer* Policy Paper No. 30 | April 2016.05.29; Center for Democratic Development (CDD), Accra, Ghana
2. Cleary S, Birch S, Chimbindi N, Silal S, McIntyre D. Investigating the affordability of key health services in South Africa. *Soc Sci Med.* 2013 Mar;80:37-46

## Contact Details:

[southafrica.phm@gmail.com](mailto:southafrica.phm@gmail.com)

<http://phm-sa.org/>

Tel: (021) 447-25-25