CHESAI

collaboration for health systems analysis and innovation

Submission to Parliament on the National Health Insurance Bill
Presentation June 22nd 2021

Introduction

Our submission was made on behalf of CHESAI (Collaboration for Health Systems Analysis and Innovation) - a collective of public health academics, engaged in teaching, research and policy advocacy. We are health policy and systems researchers from UWC, UCT and SUN

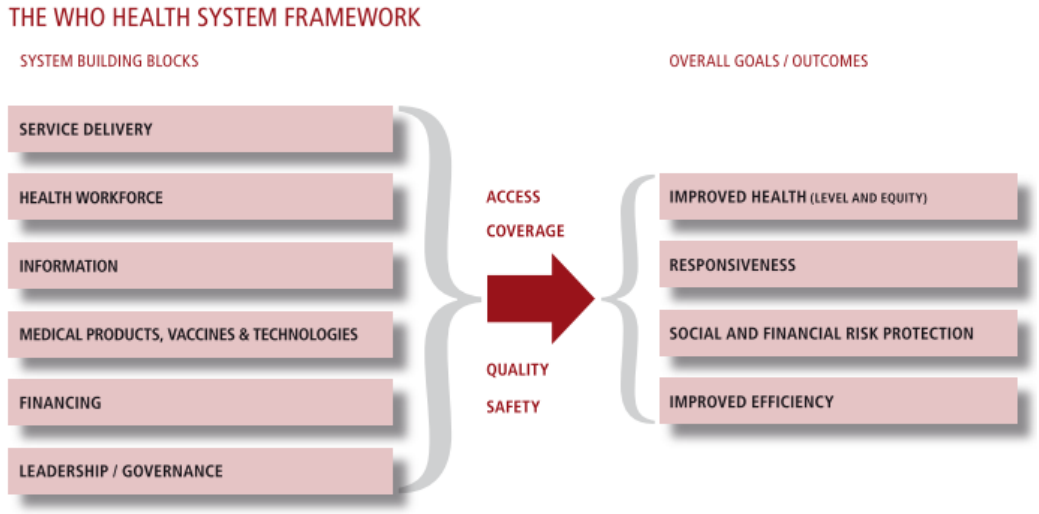
Although the submission was written pre-Covid-19, it is important to learn the lessons of the pandemic, which highlight the importance of many of the issues we will speak about today.

History of the NHI in SA

- SA's journey to equitable universal health care has been long, and various proposals have been put forward over the years
- All of these proposals are informed by the social and political context in which they emerge
- It is appropriate that in determining how to structure the funding of our health system, we consider our national values and ideals
- Many of the comments and proposals put forward in our submission, are informed by a concern with the extent to which the Bill diverges from the principles laid out in the 2017 White Paper.

Health systems are complex

- Achieving an equitable financing arrangement will not resolve the myriad of quality and service delivery challenges that pervade both public and private sectors.



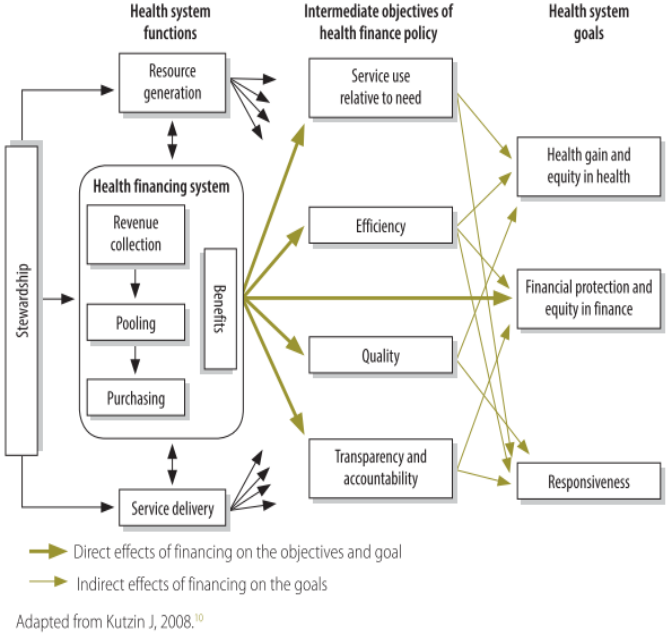
Learning health systems

- We suggest that legislative changes not be front-loaded into the initial period

- Institutional mechanisms and organisational arrangements should:

  - Be developed and tested in the initial phases, and codified in legislation thereafter
  - Be an explicit part of the organisational structure of the NHI Implementation Unit
  - Include a range of actors such as NHI Implementation Unit, the NDOH more broadly, provincial actors, facility managers, front-line providers and researchers.

Fig. 2. **Health system goals and health financing policy objectives**



Adapted from Kutzin J, 2008.[10]

Learning health system (cont.d)

- The NHI Fund is only one aspect what is needed to achieve good quality, universal and equitable health care in South Africa.

- Some provisions in the Bill not relating directly to the establishment and governance of the NHI Fund (such as the designation of central hospitals as national government components, and the reimbursement mechanisms for emergency medical services) are overly prescriptive, and will hinder future efforts to reform other aspects of the system.

    - Option 1: Remove extraneous sections of the Bill to allow more time to develop proposals testing and learning as well as through consultation.
    - Option 2: Reduce the level of detail and include provision for learning from experience to generate further proposals

Health systems strengthening

- The implementation of the NHI, and the establishment of a single purchaser (the NHI Fund) will affect health system functioning including quality of care of governance of healthcare facilities
- As such, health systems strengthening should form a part of it's technical capacity
- We propose that an entire technical committee be established devoted to HSS
- Sub-committees should be established at provincial and district level to ensure bottom-up feedback and learning

Contracting and Accreditation

- The public health sector is the backbone of the Health system
- The accreditation and contracting procedures as currently stipulated in the Bill could result in de facto privatisation

We suggest that:

- The Bill state unambiguously that the goal of the NHI is to strengthen, build on and complement the current public health sector
- Provisions be made for circumstances in which public facilities do not meet accreditation standards
- Accreditation processes take into account quality issues typically seen in the private sector
- The Bill include provisions for ensuring the rights of the country's health workforce are protected under contracting arrangements

Governance - Autonomy and accountability of the Fund

- The Fund and its Board members should be ultimately accountable to parliament, and the powers of the Minister should be reduced to minimise the risk of political co-option
- Ensure a balance of political and administrative actors on the Board, including political appointees, technical experts and civil society representatives
- This would also ensure that long-term strategic planning for the Fund is not restricted to political cycles
- The Bill should be amended to stipulate that decision-making processes of the Board (including the process of appointing Board members) should be transparent
- We propose that the selection process for the CEO of the Board be open (such as that of the SARS commissioner)

Governance - Technical and Advisory Committees

Technical committees

We propose that the process of selection for members of technical committees be transparent

- And that technical committees include representation from civil society to ensure that a range of interests are represented.

Advisory committees

- No details are given about the powers of these Committees
- We suggest that the Benefits Advisory Committee include civil society representatives
- We suggest that the Stakeholder Advisory Committee could be used to add a layer of accountability
- To enable this, its powers should be further defined, and its members stipulated to include representation from civil society and marginalised communities

Stewardship for implementation of the Fund (1)

- The Bill is currently silent on the implementation of the Fund.
- The phasing of NHI does not consider how to develop system capacity through implementation and over time. The Bill seems to take a top-down approach to system design and implementation. This will lock the system into ways of operating which may be revealed to be inappropriate or inefficient or result in negative equity consequences in the long term.

Suggestions:

- It is necessary to clarify some basic principles for implementation of the Fund as well as wider health system reforms arising out of the Bill – for example: support for experimentation, the need for learning and evaluation, and resources for capacity development. These should be explicitly stated in the Bill.

Stewardship for implementation of the Fund (2)

Suggestions:

- With regards to the NHI implementation Unit, mechanisms for feedback and learning should be an explicit part of the organisational structure of the Unit. Importantly, this can't happen entirely at National level and must allow for learning from service delivery and community levels that supports further implementation. The Implementation Unit must value and support bottom-up learning, and build system capacity through continuous feedback loops.
- In addition, it is critical that parallel efforts are taken to strengthening leadership capacity across the system. An approach to developing system capacity should be developed that includes the NHI Implementation Unit, the NDOH more broadly, provincial actors, facility mangers, front-line providers and researchers.
- The process of implementing new organisational arrangements should allow for experimentation and learning, and for capacity development (including in leadership) over time.

Stewardship for implementation of the Fund (3)

Example:

- Phase 1 could start by further developing reform design details (such as finalising the design of district and sub-district level organisational arrangements, including performance measurements and indicators), and, in parallel, developing plans for a phased implementation process across districts/sub-districts.
- Phase 2 could include waves of implementation at district level, based on district or sub-district performance measured against specified outcomes and goals. As capacity at the district level is strengthened, greater authority could be delegated.
- Such a process would allow the capacity of relevant organisational units to be developed over time, with greater levels of authority delegated to relevant organisational units over time based on performance

Health requires more that health care: The importance of addressing the social determinants of health

'The White Paper on NHI recognises that good health is an essential value of the social and economic life of humans and is an indispensable prerequisite for poverty reduction, sustained economic growth and socio-economic development. To that effect, the critical role played by Social Determinants of Health (SDH) in contributing towards improved health outcomes and a long and healthy life for all South Africans is recognised. This requires a multi-sectoral approach of addressing SDHs. NHI aims to transform delivery of healthcare services by focussing on health promotion, disease prevention and empowered communities.'

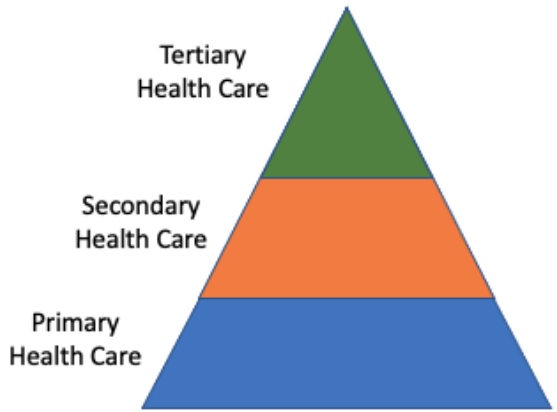
(Page 1, 2017 White Paper)

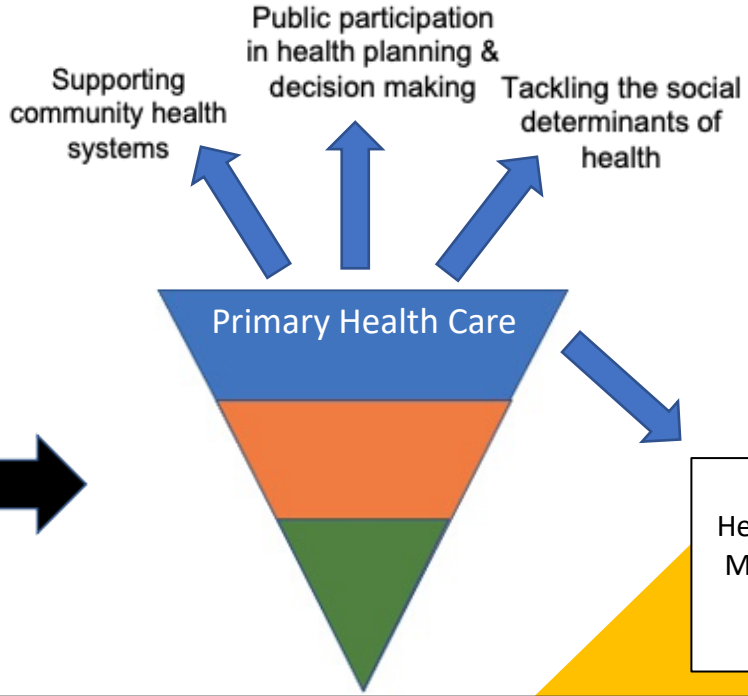
The current NHI Bill has a curative, hospi-centric focus and does not support the inter-sectoral action

- Inter-sectoral action is necessary to support health promotion, disease prevention and address the social determinants of health.
- It is as important that these receive adequate financing and are not undermined by the way healthcare is perceived and financed under NHI.
- The current bill contradicts the principles related to addressing social determinants of health outlined in the NHI White Paper

Suggested alternatives: In Table 2 of our written submission for sections 'Definitions' and 'Preamble' we suggest some alternatives to reflect the spirit of Alma Ata, and the principles outlined in the 2017 White Paper.

Turn the health system upside down





Primary Health Care is MORE THAN service delivery

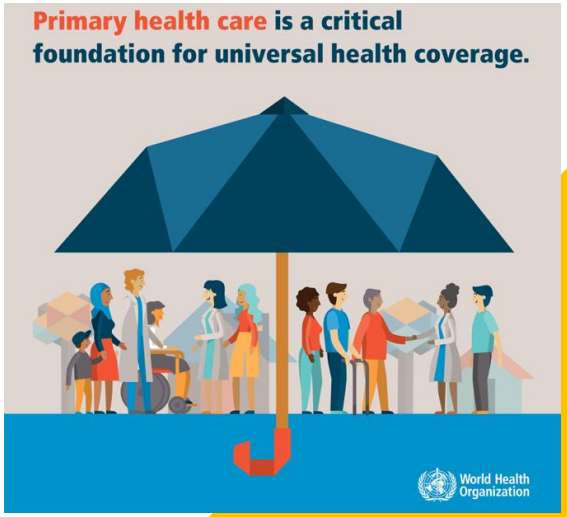
The principles of Primary Health Care need to be highlighted in the bill

We suggest adding the following to the Preamble under the heading ‘In order to’:

1. Add the following to second bullet: “Make progress towards achieving Universal Health Coverage and address the social and economic determinants of health”

2. Add the following additional clauses:

- “Strengthen primary health care, as proposed in the Alma Ata and Astana Declarations of 1978 and 2018, respectively, as the cornerstone of UHC”;
- “Substantially strengthen the current public health system as the backbone of NHI”



Example of services operating using the comprehensive PHC model: Pholela Health Unit

- South Africa had a good example of COPC in the 1940's
- The Pholela model transformed the concept of primary care from solo general practitioners offering office-based curative care for individual patients to a personal, family and community-orientated practice. This practice was a multidisciplinary team, based in a health centre, but working extensively within a defined community. The team was also inter-disciplinary and combined health, social and psychological sciences.

A demonstration on infant bathing to a group of mothers at the health center. Courtesy of Sidney L. and Emily Kark.

Lessons from Covid-19

"Based on lessons learned from HIV and Ebola on the importance of working together with communities, it is time for policy makers to shift to a less patriarchal approach and engage with, rather than shield, communities so that communities have agency and voice in developing the response. A two-way dialogue with formal and informal leaders is an evidence-based approach to addressing fear, misinformation, and contextualising the response for those at risk of severe outcomes"

(Lancet, 2020)

Principles of universality: None of us are safe until we are all safe (1)

Chapter 2: Defining population coverage:

Statement 9 of the 2019 UN draft declaration on UHC recognises that “Universal Health Coverage implies that ALL PEOPLE have access, without discrimination, to nationally determined sets of needed promotive, preventive, curative, rehabilitative and palliative essential health services that are safe, affordable, [and] effective...” If the NHI aims to achieve UHC, then it needs to define population coverage as ALL PEOPLE within the borders of South Africa.

This is supported in the constitution, which states that everyone has the right to access healthcare services and no-one may be refused emergency medical treatment. The National Health Act also confirms that all persons in South Africa can access primary health care at clinics and community health centres; all pregnant or breastfeeding women and children under the age of six are entitled to health care services at any level.

Principles of universality: None of us are safe until we are all safe (2)

<u>Suggested ammendments to Chapter 2</u>:

1. Asylum seekers, undocumented migrants, students (including foreign nationals on study visas) and ALL children should be included as beneficiaries to Section 4 (1).
2. Section 4 (2) on asylum seekers and illegal foreigners should be removed.
3. Universal Health Coverage must adhere to the principles of universalism. Language about “illegal” foreigners should not be used in the Bill.

Closing comments

- Inequalities in health and access to healthcare are, in large part a result of the stark divisions of our health system, in which funding is fragmented, giving rise to an overburdened and under-resourced public sector, and an inefficient and largely unregulated private sector.
- The maldistribution of resources between these two sectors constitutes a catastrophic injustice that risks destabilising the foundations of South African society.
- We believe that equity in health cannot be achieved without equitable distribution of health resources (both public and private) and burden of paying for health care based on the principle of social solidarity.
- This is in line with the principle of social justice, and with the South African constitution, which holds access to health care to be a fundamental human right, and not a commodity that can be bought by the rich.
- We fully support the goal of ensuring financial protection from the costs of health care, and recognise and support that cross-subsidisation requires the pooling of revenue across sectors and geographical divides.

Thank you!

CHESAI

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UNIVERSITY of the WESTERN CAPE

School of Public Health and Family Medicine
Isikolo Sempilo Yoluntu kunye Namayeza Osapho
Departement Openbare Gesondheid en Huisartskunde

UNIVERSITY OF CAPE TOWN
IYUNIVESITHI YASEKAPA · UNIVERSITEIT VAN KAAPSTAD