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catalysts for social justice

SECTION27 SUBMISSION ON THE NHI WHITE PAPER

7 June 2016

INTRODUCTION

1. SECTION27 is a public interest law centre that seeks to influence, develop and use the law to protect, promote and advance human rights. Our name is drawn from section 27 of the Constitution which enshrines everyone's right to health care services, food, water and social security.

2. SECTION27 welcomes the release of the White Paper on National Health Insurance (White Paper) for public comment. As an organisation that is committed to the realisation of the right of everyone to have access to health care services including reproductive health care and the right not to be refused emergency medical treatment as entrenched in section 27 of the Constitution, we support universal health coverage.

3. We thank the National Department of Health (the Department) for inviting comments to the White Paper.

4. We are in agreement with the White Paper's recognition that "Prior to the 1994 democratic breakthrough, South Africa had a fragmented health system designed along racial lines. One system was highly resourced and benefited the white minority. The other was systematically under-resourced and was for the black majority". SECTION27 notes that the remnants of that racist and inequitable system still linger in post-apartheid South Africa and see health system reform as vital to the broader vision of equality. We have, therefore, always been committed

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to working with the Department in the development of a policy that aims to realize the right of everyone to have access to health care services and that gives credence to equality, dignity and fundamental human rights.

5. SECTION27 has, since as early as 2008, worked with the National Department of Health in the development of NHI policy. We have made detailed submissions and have met with the Department in the early policy-making stages including on the Ministerial Task Team and other structures and in relation to a previous draft of the White Paper. We have provided the Department with advice and research on a range of specific topics, most recently including District Health Authorities,[1] migrant health, evidence-based policy, and the importance of public participation,[2] and piloting NHI.[3] We will not, therefore, repeat arguments already made.

6. We are, however, deeply concerned about the dire state of the health system at present:

6.1. The Office of Health Standards Compliance assessment of health establishments has indicated that on average health facilities across the country achieved 46%. This suggests that most health facilities are unlikely to be of standard to support NHI. This information can be found online.[4]

6.2. Our work in the Eastern Cape on emergency medical services shows widespread lack of access to emergency medical treatment, a constitutional right that is not subject to progressive realization.

6.3. Appallingly slow progress on the policy on community health workers and the continuous abuse of such health workers by provincial departments of health has seen both the arrest of community health workers in the Free State for peacefully protesting their dismissal, and the attempt by the Gauteng Department of Health to force community health workers to enter

[1] "The legal implications of the establishment of District Health Authorities" 7 October 2013.
[2] Three submissions provided to the Department in November 2012.
[3] "NHI pilot districts business plans 2013/14" 25 April 2013.
[4] http://www.samed.org.za/Filemanager/userfiles/Public%20Health%20Facilities%20audit%20results_Office%20of%20Health%20Standards%20Compliance%20briefing.pdf

into employment contracts with a payment system company, appointed initially to manage payroll and attendance, with the result that patients across the province are being left without care to develop bedsores and infections.

6.4. Stock outs of essential medication continues across the country.

6.5. The private sector, inadequately regulated while we waited for the Competition Commission Market Inquiry, is expensive and powerful.

6.6. Provincial departments of health, riding on political tensions, stubbornly refuse to implement national policy and legislation.

7. A dysfunctional health system costs lives. Unfortunately, our health system has been in a state of dysfunction for some time. While universal health coverage is undoubtedly needed, for NHI to function, it needs a strong base in accordance with the WHO Health System Framework building blocks. We do not have that base.

8. In March 2009, SECTION27's (then AIDS Law Project's) Adv Adila Hassim wrote that ALP and the Treatment Action Campaign "fully support and call for health reform initiatives [at that time in the form of the ANC NHI proposal] … However, health reform measures must be capable of implementation… In its current form, the ANC position on NHI is not capable of implementation within the proposed timeframe (five years) or on the platform of the current public health system." She went on to lay out a number of prerequisites for NHI, taking into account South Africa's Constitution, economy, unemployment, social needs, disease burden, and state of the health and fiscal systems. She suggested that if NHI is to be rolled out in a manner that is effective and that will actually achieve the objective of advancing equality in access to quality health services, the following will have to be addressed:

8.1 The human resources deficit, both for the provision of health care services and for proper management of the health system at all levels.

8.2 Insufficient and poor quality infrastructure in the public sector including a lack of facilities in rural areas.

8.3 Financial resources to pay for the “package” of service.

8.4 The currently inefficient procurement and supply-chain management of drugs, diagnostics and other medical consumables.

8.5 A very efficient system for the registration of people who NHI covers and efficient collection system for contributions to the NHI Fund.

8.6 A very efficient administration process to ensure access to quality services, monitoring, evaluation and quality control, complaints processes etc.

8.7 Oversight of compliance by provinces and local government of national health priorities.

8.8 Oversight of budgeting for health by provincial departments and expenditure.

9. While some thinking on NHI has changed since 2009, much has remained the same and many of the prerequisites, laid out at that point, remain elusive. The White Paper touches on issues of human resources, infrastructure, funding of NHI and a health information system (as did the Green Paper before it) but insufficient detail is provided to enable an assessment of the prospects of success of interventions and insufficient progress has been made thus far. The administration process and issues of management and governance remain extremely opaque. The roles of provinces, districts and municipalities has been obscured. The Treasury Discussion Document has never been made public.

10. It is not our argument that the health system should reach a state of perfection before NHI is implemented. This is, of course, impossible. However, we are very far from a functioning health care system and the White Paper lacks specificity on how the serious defects in the system will be overcome. It is imperative that planning is adequately developed to ensure a smooth re-arrangement of the national health system and to create a strong platform for moving towards an integrated health system that promotes financial risk protection and offers universal coverage.

11. With that said we move, not to repeat submissions made previously, but to raise briefly a few issues that need further consideration.

12. This submission has three themes:

12.1. First, we tackle issues that we believe are critical in health system improvement. These are the lynchpins of the health care system; system improvements upon which NHI relies and that will make a significant difference in the realisation of the right to health care services for everyone.

12.2. Secondly, we comment on the White Paper's silence on the politically difficult issue of the roles of different spheres of government and accountability within NHI.

12.3. Lastly, we raise some logistical issues in relation to the implementation of the NHI.

13. In addition to the content of this submission, SECTION27 endorses the Migrant Health Forum submission in relation to the impact of the White Paper on refugees, asylum-seekers and undocumented migrants; and the Rural Health Advocacy Project submission on priority issues for rural health.

KEY HEALTH SYSTEM IMPROVEMENT NEEDS

14. Our experience in health system advocacy, which includes human rights education and working with community based organisations in strengthening health care services and health establishments, suggests that there are some areas or issues that deserve greater focus within the health system strengthening initiatives led by the Department in the move towards NHI. We are concerned that these areas of focus have not been adequately dealt with in the White Paper or in health systems reforms thus far. They include:

14.1. weak Emergency Medical Services systems with problems that will not be resolved merely through the additional use of private providers; the resourcing of the Office of Health Standards Compliance;

14.2. issues of governance, including in relation to clinic committees and hospital boards;

14.3. the policy and employment position of Community Health Workers; and

14.4. concerns relating to human resources and retention.

15. We deal with each proposed area of focus in turn.

Emergency Medical Services

16. The White Paper notes the need to use both public and private ambulances and emergency centres to provide emergency medical treatment to anyone who needs it. It is specific in stating that all ambulances will be of the same colour and will be accessible through the same telephone number. We support this approach. We are also aware of the National Department Health's focus on Emergency Medical Services (EMS) as an area for regulatory reform and its current efforts to make the required changes to the regulatory framework.

17. Our concern centres on the unavailability of quality and appropriate EMS in the public or private sectors in many parts of the country especially in rural areas with often very difficult terrain.

18. This concern is illustrated by our experience in the Eastern Cape. On 25 and 26 March 2015, the South African Human Rights Commission held a hearing into EMS in the Eastern Cape. The hearing followed a complaint to the Commission from the community of Xhora Mouth, a collection of rural villages in the former Transkei. The Commission heard how, in some parts of the Eastern Cape, people had never before seen an ambulance in their village. When they required emergency medical treatment they would have to forego that treatment, or to pay huge sums of money for private cars to transport them to health facilities. In

many parts of the province, ambulances, while available, were notoriously unreliable, taking up to several days but usually 6 – 8 hours to arrive at a scene often with only one staff member on board (who would need to drive the vehicle rather than provide care) and with limited equipment or medication. These ambulances were little more than inefficient taxis.

19. The Commission found that the Eastern Cape Department of Health did not have a clear and rational policy about the ambulance to population ratio or response times and was not complying with its own plans. Its policies were not transparent, and its plans did not accord with its budgets. The Commission made a number of recommendations and requested that the Department report back to it within six months of the publication of the report. It has since done so. The Commission's report, the English and IsiXhosa versions of the publication of the Eastern Cape Health Crisis Action Coalition (ECHCAC) on EMS, the department's response and the ECHCAC analysis of that response are available online.[5]

20. The poor state of the EMS system in the province, particularly in rural areas, and its impact on the health of the population, is evident from the Commission's process. This is important in the context of the development of NHI policy. There are very few private providers of EMS in the rural areas and so the incorporation of public and private providers into the system would not resolve the problem.

21. What is required urgently is the provision of more, and more appropriate, EMS vehicles; the employment of qualified skilled personnel; the development of monitoring and tracking systems; the employment of more personnel and the publicising of complaints mechanisms. This, we argue, requires that in settings that are rural, there needs to be a greater and different allocation of resources

[5] http://section27.org.za/wp-content/uploads/2015/10/SAHRC-Report-on-Access-to-Emergency-Medical-Services-in-the-Eastern-Cape-2015-1.pdf the English and IsiXhosa version of the ECHCAC publication is available here http://section27.org.za/2015/10/ems-in-the-eastern-cape/ and the Department's response to the Commission can be found here: http://section27.org.za/publication/ecdoh-response-to-sahrc-report-on-ems/ and the ECHCAC reply to the department's response can be found here: http://section27.org.za/publication/echcac-reply-to-ecdoh/

(financial and otherwise). For a detailed account of the need for differential funding of rural health and in particular EMS in rural areas, see the Submission on National Health Insurance White Paper by Rural Health Advocacy Project.

22. The specific need to improve the public sector EMS system given the unavailability of private services in some areas is not dealt with in the White Paper. The improvement of the EMS system would go a long way to ensure universal access to health care services in an emergency if the above issues were considered.

Office of Health Standards Compliance

23. The Office of Health Standards Compliance has a central role in ensuring quality health care services and we applaud the appointment of Professor Malegapuru Makgoba as the Ombud of the Office of Health Standards Compliance (OHSC). The OHSC has, thus far, shown itself to be an independent body with qualified and dedicated personnel, albeit insufficient personnel and resources to fulfil its important mandate. On 4 February 2015 the Eastern Cape Health Crisis Action Coalition lodged a complaint about Holy Cross Hospital in the Eastern Cape with the OHSC, which precipitated its first investigation and the testing of its processes. The OHSC paid two visits to the hospital, produced two reports (dated 4 March 2015 and 11 January 2016), and is working hard to ensure that its recommendations are implemented and that conditions are substantially improved at the hospital.

24. Our experience of the OHSC indicates its potential to fulfil its mandate very successfully. It is vital, however, that its financial and human resources are sufficient to allow it to do so. We are aware that the OHSC's funding levels at present are far from what would be required to perform the function provided for in the White Paper. At a March 2016 presentation to the Parliamentary Portfolio Committee on Health, Prof Lizo Mazwai, Chairperson of the OHSC, noted that the OHSC would require R60 million in order to meet its inspection target.

The OHSC has set itself a target of inspecting 20% of health establishments in the public sector and 30% of health establishments in the private sector over a five year period.[6] At this rate public health facilities would be inspected once every twenty five years – not nearly frequently enough to ensure access to quality. More resources are clearly required if the OHSC is to play the envisaged central role in ensuring quality.

25. The OHSC must be fully capacitated urgently (at latest within the next financial year) to assist it to play its role in improving the quality of health care services currently being accessed and intended to be accessed once NHI is operational.

Governance: Clinic Committees and Hospital Boards

26. Clinic committees and hospital boards are a fundamental component of the South African health system and are intended to be part of the planning, prioritisation and management of health services.[7] They thereby contribute to the development of district health plans and budgeting processes. Moreover, they are purposed to partner with health facility staff to strategically guide the operation of the clinic to make it more responsive to the needs of the local community.[8]

27. The existence of these community governance structures and particularly their optimal functioning ensures the effective governance and the accountability of the health services to communities.[9]

28. Although there are multiple policy documents that entrench these community governance structures in the health system, there is evidence that the implementation of health committees has been uneven at best.[10]

[6] OHSC Annual Performance Plan 2016/17.
[7] "Community Participation in the Post-Apartheid Era: Progress and Challenges" in M.P Matsoso et al, *The South African Health Reforms* 2009-2014 (Juta 2015) p224 – 236.
[8] Ibid p226.
[9] Ibid p226.
[10] Ibid p228.

29. In 2003, only 59% of clinics and community health centres had clinic committees and not only had this figure remained static since 2000, it transpired that only 35% of these had met in the recent past.[11] Further to this, in 2008, the National Department of Health found that only 57% of clinics reported having clinic committees.[12] The province that reported the highest number of clinic committees was the Eastern Cape with 73% of facilities reporting having clinic committees and the province with the lowest was Mpumalanga with 31% of facilities report having clinic committees.[13]

30. In our experience we have found that in some health facilities, clinic committees function very well by providing an important link between the facility and the users of that facility. Unfortunately, because there is no national standard for the structures' role and function, election or appointment of members, training or empowerment, their impact is patchy. In some health facilities the governance structure is very politicised and members are appointed by ward counsellors. In others, members are appointed by Operational Managers and are accountable to them. Few clinic committees have been trained on their roles and the tools available to ensure that they are able to fulfil those roles.

31. The White Paper envisages an enhanced role for these governance structures. They should represent community views and perform a health promotion role. There is little indication, however, of how this very dramatic change will occur.

32. First, in order to ensure the optimal functioning of clinic committees and their uniform existence, the following has to be taken into consideration. There should be an urgent development of the national guidelines on clinic committees to harmonise legislation and practice across provinces (albeit most provinces do not have legislation on clinic committees). The guidelines could echo the principles from the Policy on the Management of Public Hospitals.[14] The guidelines should

[11] Ibid p228.
[12] Ibid p228.
[13] Ibid p229.
[14] Policy on the Management of Hospitals in GN 186 GG 35101 of 2 March 2012.

clarify a range of procedural issues such as the means of constituting and operating governance structures, nomination procedures, terms of office, roles and responsibilities, communication channels, codes of conduct and how governance structures' functionality is maintained. The South African Schools Act 84 of 1996 is instructive in that it is specific in describing both the responsibilities of School Governing Bodies (SGBs) and the obligations on provincial departments to oversee the operations of SGBs, develop codes of conduct and processes for election, provide training etc. A similar approach should be taken to health committees. The Guidelines Relating to the Elections of Governing Bodies of Public Schools may offer an example as to how this should be done.[15]

33. Secondly, if these governance structures are to fulfil their envisaged role it is critical that a detailed training programme is developed and conducted for clinic committee members. The training must ensure that members of clinic committees will be knowledgeable about issues relating to the right of access to health care services, governance of health care facilities, understanding community needs, conflict resolution and dispute management. Funding should be provided for the training of clinic committees. Such training of clinic committees could be at district or sub-district level, depending on the geographical landscape of an area and budget available. The various districts and sub-districts may employ trainers on periodic fixed term contracts to conduct the training.

34. Thirdly, issues related to local government must be addressed. One such issue is linking meaningfully local government and health services. Ward councillors particularly must be trained regarding their role in clinic committees. It must be ensured that a key performance area for a ward councillor is compliance with the requirement to participate in clinic a committee(s).

[15] http://www.education.gov.za/Portals/0/Documents/Publications/Guidelines%20Relating%20to%20Electing%20SGB%20draft%202.pdf?ver=2014-12-19-084124-000 accessed on 6 May 2016.

35. Finally, clinic committees and hospital boards cannot be expected to operate without funds. While it may be appropriate that, like SGB members, clinic committee members are not remunerated, it is impossible for them to play a governance, oversight and health promotion role without funding. It is also impossible for them to be adequately equipped to play this role without being trained - an exercise that also requires funding. The White Paper gives no indication of the budget for, or plans to fund the operation or training of, clinic committees and hospital boards.

36. As increasingly important components of health establishment governance, clinic committees and hospital boards should not only be given more responsibility and functions but should be capacitated to take such responsibility and additional functions on. This can be achieved through the development of guidelines and through funding.

Community Health Care Workers

37. There has long been recognition of the importance of Community Health Care Workers (CHWs) to a health system based on prevention and primary health care. The White Paper makes mention of CHWs once - as components of Ward Based Primary Health Care Outreach Teams (WBPHCOT) - but provides no further information. The Municipal WBPHCOT Policy Framework and Strategy has been in draft form since 2012. The "Investment Case for Ward-Based Primary Health Care Outreach Teams" was, we understand, recently presented to Treasury. It outcome is unclear.

38. In the meantime, the treatment and status of CHWs in different provinces differs markedly. CHWs are not recognised by the formal public health sector, their qualifications are not standardised, and they are largely employed by NGOs.

39. In Free State, CHWs were dismissed and on 10 July 2014 over 100 were arrested for protesting their dismissal. In Gauteng, the provincial department is attempting

to shift the employment of CHWs to a payroll management company. While this in itself is a very problematic approach, in addition no provision has been made for the transitional period and as a result patients who had been receiving home based care are suffering considerably.

40. CHWs are vital to the reliable provision of health promotion and prevention services and basic health care services. They will also be indispensable for implementation of the new HIV "test and treat" policy, announced in the Minister's budget speech on 10 May 2016. Research to be published shortly by Medicins Sans Frontiers suggests that the withdrawal of lay counsellors in uMlazi Municipality substantially decreased clinic based HIV testing. If these findings are representative of the experience province-wide (and potential experience nationwide), they illustrate how lay counsellor withdrawal may jeopardize efforts to deliver the 90-90-90 strategy.

41. Given the role of CHWs in realising the vision of National Health Insurance, the continued uncertainty at national and provincial level and in the White Paper can no longer be accepted. We therefore request an urgent timeframe for the conclusion of the policy development and implementation process.

Human Resources for Health and retention

42. There is mention in the White Paper of the importance of human resources to the success of NHI. The 2012 National Human Resources for Health Strategy is alluded to as the roadmap for the planning, development, provisioning, distribution and management of human resources. Specific mention is made of the "rapid production" of specific categories of health professionals, the use of WISN, the need to incentivise health workers to provide service in rural areas, and the need for retention strategies.

43. We have three primary concerns about the way in which the National Department of Health intends to deal with the issue of human resources. First,

the 2012 strategy is just that: a strategy giving broad direction and not a plan, the implementation of which has been considered.[16] While we agree with much of the direction of the 2012 strategy, we are concerned that there appears to have been no further action towards the development of a comprehensive human resources plan and its implementation. The Minister has not developed regulations on human resources, as he is empowered to do by section 90 of the National Health Act,[17] which means that there is no consistency in human resources planning across provinces. The WISN tool has been in the process of implementation for many years. A number of provinces, including KwaZulu-Natal, the North West and the Eastern Cape, have in the past year frozen posts or instituted moratoria on the hiring and replacement of staff due to budgetary constraints.[18] A plan based on the 2012 strategy is urgently required.

44. Our second concern relates to retention. The White Paper provides only that "improving the quality of life of health professionals working in rural areas will require a multi-sectoral response to providing basic social infrastructure and amenities". This statement suggests, first, that retention is only a problem in rural areas. This is not the case. Second, it appears to relegate the problem of retention to one requiring action by other sectors, presumably including Departments of Roads, Education, Water and Sanitation etc. The difficulty here is that research by Africa Health Placements among others, and our own experience, has shown that there are many reasons why health care workers leave the public health system. Some would require multi-sectoral responses but many are directly health system related: poor management, under-staffing, medication stock-outs, the unavailability of equipment, non-payment of salaries or over time etc. These are some of the most common reasons health care

[16] M Heywood 'The broken thread: Primary Health Care, Social Justice and the Dignity of the Health Worker' 1 September 2014 available at https://www.wits.ac.za/media/news-migration/files/Heywood%20Public%20Positions.pdf

[17] Act 61 of 2003.

[18] In KwaZulu-Natal, a moratorium on the filling of vacant posts was issued on 7 October 2015. It is available here: http://www.rhap.org.za/wp-content/uploads/2015/11/KZN-Circular-staffing-moratoria-60-2015.pdf. On 25 September 2015, a moratorium was implemented in the North West. It is available here: http://www.rhap.org.za/wp-content/uploads/2015/10/Memo-by-NW-Provincial-Government_Staffing-Moratoria_September-2015.pdf. On 8 September 2015, a similar instruction was given in the Eastern Cape. It is available here: http://www.rhap.org.za/eastern-cape-doh-staffing-moratoria_september-2015/

workers leave public sector health facilities. They are also within the direct ambit of the health system and require attention if we are to improve retention.

45. Finally, and most importantly no indication is given of the budget for an improved human resources base. The Constitutional Court has repeatedly held that for a plan for the realisation of rights to be considered reasonable, appropriate financial resources must be made available.[19] In this case there is neither a plan nor a budget.

ACCOUNTABILITY AND POLITICAL CONSIDERATIONS: THE NHI FUND, THE NHI COMMISSION AND THE ROLE OF PROVINCES AND DISTRICTS IN THE IMPLEMENTATION OF NHI

46. The legitimacy of NHI will depend heavily on accountability, transparency and cooperation. There is no indication in the White Paper that these issues have been appropriately considered.

47. The White Paper currently does not offer any clarity on the responsibility and role of provinces and districts in the implementation of NHI. While this may be one of the more politically difficult issues to tackle, it is vital for those responsible for the implementation of the policy to know exactly what is expected of them in fulfilling their legal responsibilities and also for the South African public, currently caught in the middle of the structural problems between national, provincial and district authorities, to understand how NHI is going to improve the health system. Clarity will strengthen accountability and increase the chances of the successful rolling out of the NHI. It would also give credence to the principle of cooperative governance in the Constitution.[20] SECTION27 has, over the years, provided advice to the Department on this issue.

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[19] *Grootboom v Government of the Republic of South Africa* 2001 (1) SA 46 at para 30; *City of Johannesburg Metropolitan Municipality v Blue Moonlight Properties 39 (Pty) Ltd and Another (CC) 2012 (2) SA 104 (CC)* at paras 57 and 67.

[20] Section 40 (1)

48. Further, with regard to governance, we appreciate that the White Paper envisages an amendment to the National Health Act so that legislation is enacted to regulate the functioning and powers of the NHI Fund.[21] We are aware that the White Paper foresees the creation of the NHI Commission, a governance structure for the NHI Fund, which will be an external oversight mechanism.[22] We are, however, of the view that the White Paper, first, mistakenly shifts its responsibility to delineate, with reasonable certainty, the powers and functioning of the NHI Fund and the NHI Commission to legislation that will come in the future. Secondly, the White Paper fails to deal with the issue of the relationships that will need to be dexterously handled between the NHI Fund, the NHI Commission and the various tiers and structures of government responsible for the provision of health care services. Below we offer our analysis of the issues with which the White Paper should grapple in order to remove the uncertainty surrounding the NHI Fund and the NHI Commission.

49. First, the White Paper must clarify the exact nature of the relationship between the NHI Fund and the NHI Commission with the national, provincial and local Departments of Health. In our work, we frequently see the disjuncture between what the national Department of Health says or practices and what is practiced in the various provincial and local Departments of Health. The White Paper must offer clarity as to how these differences that exist now, either will not exist once the NHI Fund and NHI Commission have been established; or will not adversely impact people's right to access to health care services. Intimately connected with this are the relationships that must be formed and sustained. The White Paper has to offer guidance or at least lay the foundations of the nature and the extent of the relationships between the NHI Fund and the NHI Commission with the National, provincial and local Departments of Health.

50. Secondly, the issue of accountability is not sufficiently dealt with in the White Paper. The right of access to health care services rests, at the national level with

[21] NHI White Paper P60 at para 322-323.
[22] NHI White Paper P62 at para 327.

the National Department of Health, at provincial level with the Provincial Department of Health, at district municipal level with the district municipality and at local level with the local municipality. The White Paper needs to show how and to what extent the NHI Commission and the NHI Fund will be accountable to the Minister of Health and how and to what extent the NHI Fund and NHI Commission will interact with the other tiers of government. Intrinsically linked to this are the following:

- Will the Minister of Health have the power to veto decisions made by the NHI Fund and/or NHI Commission?
- Will the Minister of Health have powers to appoint and/or dismiss officials of the NHI Fund and/or the NHI Commission?
- How and what will the relationship be between Premiers, MECs and the NHI Fund and the NHI Commission?

51. Thirdly, although the White Paper, on page 62 at para 327-328 mentions that the NHI Commission will be a governance structure for the NHI Fund and that the NHI Fund will report quarterly to the NHI Commission, the White Paper does not set out the exact nature of this governance arrangement. For example, can the NHI Commission veto a decision of the Fund? Will the NHI Commission have powers in appointing and dismissing employees of the NHI Fund? In order to deal with these issues, the White Paper must demarcate the exact nature and extent of the NHI Commission's governance function.

52. Fourthly, there are significant challenges facing management at a facility level. Amongst the many challenges the most important relate to the lack of management in many health care facilities or the lack of skills in those who occupy management positions in health care facilities. An important element here is how the White Paper foresees the interaction between managers of health care facilities with the governance of NHI. Consideration needs to be given to situations where managers lack the necessary skills or where there is a complete lack of management.

53. Lastly, the White Paper fails to devote attention to the issue of corruption which we see as having a crippling effect on the government's capability in providing health care services.[23] More than merely stating that the NHI Commission will be an external oversight mechanism, the White Paper must give much more detail on how the NHI Fund and the NHI Commission will be insulated from corruption, abuse and mismanagement.

LOGISTICAL ISSUES IN IMPLEMENTING NHI

The NHI Card

54. It appears that the Department has returned to the idea of using an NHI card. We see no justification for the introduction of an NHI card instead of using already existing ID smart card with an adaptation for those not entitled to the ID card. The introduction of an NHI card would be an unnecessary hurdle for communities who are already struggling with accessing IDs. Use of the ID smart card and the ability for people to sign up for such cards at health facilities provides the added benefit of giving people greater access to IDs.

55. The long promised and important "unique patient identifier" for HIV and TB testing could then also be linked to ID numbers rather than creating a litany of numbers and cards for each person accessing the health care system.

Plans for the Pilot Districts

56. In 2013, the Director-General published an 18 month review of the piloting system in the South African Health Review. On 21 August 2015, the Department of Health and Treasury presented to the Health Committee of the National

[23] Laetitia C Rispel et al, "Exploring corruption in the South African health sector." Health Policy and Planning, June 2015

Assembly. The 18 month review and the presentation to the Health Committee appear to be the only publically available assessments of the pilot process.

57. On 25 April 2013, SECTION27 wrote to Dr Yogan Pillay, copying all MECs for health and District Managers of NHI Pilot Districts, about the absence of clear planning (as demonstrated by wholly inadequate business plans across all NHI pilot districts), and the purpose of piloting. The reason for this enquiry was that piloting, if done right, provides an important opportunity to test interventions and gather evidence. We did not receive a response to this letter nor to follow up letters.

58. It now remains unclear whether the pilots have achieved their purpose and have influenced the development of the White Paper. Given that the reason for piloting is to test innovations, there should be reflection on piloting and consideration of outcomes in the policy development process. It remains unclear what the condition of the pilot districts is; what lessons have been learnt during the time in which NHI has been piloted; whether piloting is over or, if not, for how long piloting will continue. It appears from the presentation to the Health Committee that the GP contracting programme has been largely unsuccessful (with only half of the target of GPs contracted) and yet a change of approach to reflect consideration of this fact is absent from the White Paper. Pilot Districts have repeatedly failed to spend the funding provided, bringing into question how further decentralised service provision at the level of districts could work.

59. While the pilot process provided important opportunities, it was not appropriately designed or planned for to deliver the kind of evidence required and the lessons learned, if any, appear not to have been incorporated into the White Paper.

Timeframes

60. The current timeframes do not give the Department enough time to ensure that implementation of the NHI is successful. We suggest that the Department increase the timeframes it has set for the implementation of the NHI such that more time is given to address the issues detailed above and investigations regarding some of the finer details in the implementation plan.

61. The setting of unrealistic timeframes creates unrealistic expectations from health service users and from those implementing the policy. There is little doubt that it will not be possible to fully implement NHI by 2025. There is no reason, therefore, for the Department to set itself up for failure.

62. We request further information from the Department about the process going forward. In particular, please indicate:

62.1. whether a legislative audit has been conducted to consider the impact of NHI on existing legislation;

62.2. whether a draft Bill or Bills has/have been prepared and if so, when it/they will be tabled;

62.3. what the process for further consultation will be; and

62.4. what the timeframes are for further policy and legal development.

CONCLUSION

63. We thank the National Department of Health for providing this opportunity for submissions on the NHI White Paper and trust that our submission will be useful in the further development of NHI policy.

For queries on this submission, please contact:

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