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21 November 2019

The Acting Director General of Health
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Dear Dr Pillay

PsySSA written response on the National Health Insurance (NHI) Bill

Thank you for the opportunity for members of the Psychological Society of South Africa (PSYSSA) to comment on the NHI Bill. These comments follow on from our previous submission to the NHI White Paper, dated 25th May 2016. The process of gathering comments from our members for this submission began at our recent annual PsySSA Congress, held in Johannesburg from 3-6 September 2019, during a roundtable debate on the implications of NHI for mental health care. An ad hoc committee led the subsequent process of gathering comments from all of PsySSA's structures in order to compile our current position statement and comments on the Bill.

PsySSA was formed in 1994 and is the representative body for psychology professionals in South Africa. PsySSA is a registered non-profit organization and a voluntary professional association, the largest in psychology on the African continent, with 11 special interest divisions, 12 standing committees and provincial branches. Governance oversight is provided in between Annual General Meetings by Council and an Executive Committee. PsySSA membership includes all psychologists (clinical, educational, counselling, research, industrial, and neuropsychology), psychometrists, registered counsellors, and psychology students registered with the HPCSA. We are a non-partisan, unifying organization for all psychology professionals that seeks to advance South African psychology as a science and profession of global stature, and promote psychological praxis which is relevant, proactive and responsive to societal needs and well-being within our context. PsySSA therefore has a vested moral, social and clinical interest in the NHI generally, and in related psychological services more specifically.

There is no doubt that our health system needs dramatic reforms at every level to undo the inequity in access to health care, which arises from the enduring legacy of apartheid. The current process presents an opportunity to step up implementation of policy commitments to improve service access, delivery and outcomes to promote health and the often overlooked psychosocial and mental health needs related to holistic health. PsySSA supports the spirit of the NHI Bill and its principles, goals and objectives. We support universal health coverage and the idea that health care should be viewed as a social investment for a healthy and productive society predicated on equity and social justice. We wish to convey our willingness as the representative body for psychology professionals in South Africa to contribute to the development of the NHI system by providing input to all processes related to the NHI. Our members have extensive clinical, research, management and social responsiveness skills to contribute to the process of establishing and implementing the work of an NHI-funded health system. Our membership includes renowned psychologists who play leadership roles in the international psychological, scientific and health arenas, and who are able to engage experts in international best practice benchmarks.

As mental health professionals, we commit in particular to providing input relevant to supporting a health care system which will improve access to psychosocial and mental health care in South Africa.

Our specific comments to the Bill are contained in Table 1 below. We make these comments mindful that:

1. Goal 3 of the 17 United Nations Sustainable Development Goals (SDGs), in force since January 2016, explicitly notes the centrality of mental health and wellbeing to the overall health status of nations. Sub Goal 3.4 states: "By 2030, reduce by one third premature mortality from non-communicable diseases through prevention and treatment and promote mental health and well-being". Sub Goal 3.5 states:"Strengthen the prevention and treatment of substance abuse, including narcotic drug abuse and harmful use of alcohol". Goal 3, Health and Wellbeing, is also acknowledged to underpin all other goals. The priority groups identified for special focus by the SDGs are women, children, the aged, poor people, and people with disabilities (which includes people with intellectual and psychosocial disabilities). These are priority groups echoed in the focus of our public service programmes in South Africa, which resonates with the 6th administration priorities.

2. The NHI Fund should offer our country the opportunity to develop and implement interventions which are more responsive to three key mental health related areas, specifically, (1) promotion of healthy lifestyles and mental wellbeing *within communities*, and not only within health facilities;(2) more robust embedding of a *mental health orientation to physical health* promotion and treatment services; and (3) *providing adequate mental health services* for people with enduring mental illness (psychosocial disability). Additionally, attention is needed to develop and implement interventions to address the impact of the *violence pandemic and related trauma* impacting on the health and wellbeing of South Africans, as strikingly reflected in recent statistics.

2.1 *Mental wellbeing within communities*: There is extensive international and local evidence pointing to the fact that the high levels of poverty, continuous trauma and constraints to social and

economic development faced by many South Africans erodes psychological health and inhibits the resilience needed to cope with and overcome these stressors. The current traumas experienced by citizens due to gender-based violence, family murders, child rape and killings, attacks on thriving community businesses and infrastructure, living in violent neighbourhoods, and the mental strain experienced by South Africans due to state capture and increased economic vulnerability of our country, to mention a few, serve as solemn reminders of ***the need to employ psychological interventions and skills to rebuild a healthy, resilient national psyche*.**

2.2 *Mental health orientation to physical health:* The link between mental and physical health is now well established: people with poor mental health are less likely to live healthy lifestyles, impacting on their physical health (and need for health services), while people with physical health conditions (including priority conditions such as HIV and AIDS, tuberculosis, and CVD) may develop depressive and anxiety related conditions secondary to their physical health condition, impacting on treatment compliance capabilities, and recovery rates. ***Greater attention to mental health status in delivery of physical health care will be both health promoting, and cost saving in the short and longer terms***.

2.3 *Providing adequate mental health services***:** The current National Mental Health Policy 2013-2020 acknowledges the importance of promoting psychological wellbeing and preventing ill health, and sets targets for prioritization of psychological services. However, access to meaningful psychiatric care, psychological care and resilience-building interventions that are suited to our contexts remains sub-optimal for most South Africans. The National Mental Health Policy Framework and Strategic Plan (2013- 2020) and related legislation and policies must be translated into tangible benefits for mental health care users. The South African Human Rights Commission (SAHRC) report on the National Hearings on the Status of Mental Health Care in South Africa published in May 2019, clearly describes the “varying deep-rooted challenges that characterise the mental health care system in South Africa, pointing to a chronic and systemic neglect, coupled with mismanagement and a dire lack of resources”. The document explicates directions for development of appropriate mental health services for people with psychosocial and intellectual disability. ***We strongly recommend that the NHI enables the recommendations of the SAHRC report on the status of mental health care in SA.***

2.4 The SAHRC report makes special mention of the need for attention to the mental health and wellbeing of children and adolescents. The mental and physical health and wellbeing of children and adolescents (CA) should be a prime focus of our health efforts. Schools are an important setting within which to introduce interventions aimed not only at prevention and cure of illness, but also programmes to develop the values, attitudes and behaviours that promote resilient citizenship of children, and their families and create an empowered polity. Key partnerships with, for example, the Departments of Basic Education, Social Development, Justice, Health, Women and Children and Economic Development at local level are important to reach CA in crisis, CA in conflict with the law, adolescents ready for gainful occupation, and their families or supporters,

as an extension of community-oriented health promoting schools initiatives**. *Current Health Promoting Schools initiatives should be strengthened and reviewed as a framework and vehicle for delivery of a more comprehensive school health programme countrywide. This programme could be linked to the Screening, Identification, Assessment and Support policy of the Department of Basic Education.***

Detailed comments on each chapter follow in the rest of this document. General remarks are provided along with proposed changes to wording where necessary, and justifications for these changes.

Table 1: PsySSA comments on the NHI Bill, October 2019.

CHAPTER 1: **PURPOSE AND APPLICATION OF ACT**

General remarks:

- PsySSA supports the overall purpose of the Bill to "achieve sustainable and affordable universal access to quality health care services" (S2).
- The creation of a single NHI Fund in which government is "the single purchase and single payer of health care services" (S2a) must be approached with caution, balancing the philosophy of NHI with the pragmatic implementation of such a grand scheme. Read against the backdrop of our current socio-political climate and the State Capture Commission, Parliament must consider how public trust in government as transparent and accountable has sharply declined. If this fund is mismanaged, we risk destroying the entire health care system. This concern is not unwarranted, given the financial ruin of most state-owned enterprises and the inability of most CEOs and Boards to achieve their mandates.
- The pace of implementation of the NHI must ensure that every precaution is taken to maximize its effective implementation, eschewing the costly bureaucratic experience of other jurisdictions, such as the UK NHS.

Section	Comment/ Proposed changes (underlined)	Justification for change
Section (b), Definition of primary health care, page 6-7.	*(b)* in the public health sector, is the clinic service area, including community health workers, primary care nursing professional, primary care dental professional and primary allied health professional, through multi-disciplinary practices, and in the private health sector, is the general medical and other allied health profession practice.	The current wording is not clear .Public service is noted as a facility, private services as one health practitioner. Clinics do outreach through community health workers and mobile services, and this should be reflected in the definition, as well as making clear which health practitioners may offer services in the "clinic service area". We suggest amending the definition to be more clearly aligned to the more comprehensive description of the PHC service section 37 (2) on a contracting unit for PHC, which states that the unit will consist of a district hospital, clinics or community health centres and ward-based outreach teams and private providers organised in horizontal networks within a specified geographical sub-district area. The NHI fund needs to make more explicit mention of non-clinic based health services, such as community mental health services and how these will be funded. This is particularly important given the Life

		Esidimeni tragedy in Gauteng and ongoing problems with licencing, monitoring, and capacity development of day care and residential community mental health services for children, adolescents and adults with intellectual disability, and for adults with psychosocial disability. We are of the view that lack of attention to these services presents a significant risk factor for the NHI Fund and health service delivery.
Section 2 and elsewhere whereby the term "*universal access*" is used.	The term *"universal access*" is not defined, and its meaning is not obvious.	It should be one of the terms included in the *"Definitions"* section, so we all have the same understanding of its intended meaning.
2(a), line 36	*(a)* serving as the oversight system for a coordinated purchasing and payment system of health care services in order to ensure the equitable and fair distribution and use of health care services attuned to the needs of a nascent democracy on the southern tip of Africa	This idea is unwieldy for the entire country, and leaves room for the health care system to be out of touch with what is required at local levels and to have very slow response times for purchases and payments. A single purchasing and payment body may create opportunity for misappropriation of funds.

CHAPTER 2: **ACCESS TO HEALTH CARE SERVICES**

General remarks:

- It is not unclearly stated whether users have the option to register at any health establishment of their choice or whether this will be entirely dependent on geographic location and the current catchment-area model used by public health facilities. Users should have the freedom to choose the health establishment of their preference so as to not perpetuate inequities in service delivery based on apartheid spatial planning.

Section	**Comment/ Proposed changes (underlined)**	**Justification for change**
4.2 (a) and (b), line 16	(2) *Refugees,* asylum seekers or illegal foreigners are entitled to— *(a)* emergency medical services; (b) basic health services, and *(b)* services for notifiable conditions of public health concern	As a human rights oriented organisation, PsySSA cannot support any limitations on population coverage. It is a violation of human rights for people to be left without basic health care. Neglect of the basic health care of people in the country can impact on the health status of others they come into contact with, not only for notifiable

		conditions, but for other infectious health conditions. Children and young adults turning 19 who are still dependent on their families will suddenly be without healthcare. Universal health care should be provided to all human beings who require it, including refugees, asylum seekers and illegal foreigners. Alternative billing arrangements can be made between the Fund and the relevant home countries of asylum seekers and illegal foreigners. This point is especially important in the context of mental health care. Many refugees, asylum seekers and illegal foreigners suffer from depression, anxiety and trauma, having left their home countries under duress, only to live in this country under severe economic hardship and the continuous threat of xenophobia and violence. Affording them only emergency medical services does not make sense and is likely to be struck down by our courts. For example, it is easier and cheaper to treat a person with mild depression as an outpatient, than to wait for the condition to worsen to severe depression with suicidal ideation and psychotic features, which will be considered emergency services, but be far more costly to the Fund, requiring admission and more intensive treatment. It would also be unethical and irrational to then not offer any follow-up services after offering the initial emergency services. Section 4(2)(b) is aimed purely at keeping SA citizens safe from *illegal foreigners* if they have a notifiable communicable disease – thus serving to alienate them further. This is life threatening within the current prone-to-xenophobic attack climate.
5.1 line 47 And 5.8	(5) When applying for registration as a user, the person concerned must provide his or her biometrics and such other	Many South Africans still do not have identity documents, or a person might have lost their documents and, in some cases, children do not

And 6.d-f	information as may be prescribed, including fingerprints, photographs, proof of habitual place of residence and— *(a)* an identity card as defined in the Identification Act, 1997 (Act No. 68 of 1997); *(b)* an original birth certificate; or *(c)* a refugee identity card issued in terms of the Refugees Act or (d) an affidavit of citizenship to obtain a temporary access card (or similar) (5) …to allow for an adult with a mental disorder which results in him or her being unable to independently register to have a caregiver/guardian do the registration on their behalf. (8) A user seeking health care services purchased for his or her benefit by the Fund from an accredited health care service provider or health establishment must present proof of registration or temporary access card to that health care service provider or health establishment when seeking those health care services	have documents due to their parents not having documents to use to obtain these. Provision must be made for temporary access to services until formal registration documents can be procured. The NHI Bill must make provision for access to service provision in the event that the person cannot be registered for some reason, or is awaiting registration, to avoid any instance of administrative injustice. Registration of users should also not be dependent on providing *proof* of habitual place of residence (S5.5) due to high rates of homelessness, urban migration, and informal settlements in South Africa, an issue with which the IEC has perennially been grappling. This section makes no mention of the process for an adult with a mental disorder or intellectual disorder or other neurological condition who may be unable to independently register as a user. It is of concern that the rights of users to health care services is "within the State's available and appropriated resources" (S6). If the Fund is the only purchaser and provider of services, given the severe limitations imposed on what medical schemes can and cannot offer, we are concerned about how services will be prioritized and/or rationed, in the event that resources and tax income streams do not meet the expected levels.
Rights of users 6	Rights of users S6 (d) not to be refused access to health care services on unreasonable grounds;	It is unclear how "*unreasonable grounds*" and "*reasonable time periods*" will be operationalized. It should be specified what "a reasonable time period" (S6f) is within which a user can expect to

	S6 (f) to access health care services within a reasonable time period…	access services, given the long waiting lists currently in place at public hospitals Access to mental health services (particularly in emergencies such as suicidal/homicidal ideation/psychosis) needs to be immediate. Similarly, Mental Health Care Users (MHCUs) presenting with common mental disorders (such as anxiety and depression) need to access health care services without delay, as these common mental disorders can escalate into medical emergencies.
7.4 (a) – (d)	Amendment needed to section copied below: …a health care service provider ...demonstrates that*(a)* no medical necessity exists for the health care service in question;*(b)* no cost effective intervention exists for the health care service as determined by a health technology assessment; or *(c)* the health care product or treatment is not included in the Formulary, except in circumstances where a complementary list has been approved by the Minister	Lack of clarity regarding whether 'health care provider" refers to the referring or referred to provider. In some instances, assessment requires specialist assessment to identify and prescribe treatment and there is a risk that users may be turned away before adequate assessment has been conducted. This is the case for mental disorders, where competence in the primarily health system is limited for detection and treatment. The health technology assessment tools will need careful integration of mental disorders. Similar difficulties, for example, are currently being experienced by users with serious mental illness wanting to access social assistance where tools focus on physical health and are poorly designed to detect mental health conditions. Point (b) requires urgent attention to the determination of "cost effective interventions" Point (c) demonstrates the need for inclusion of mental health professionals in the determination of the Formulary. There is a danger that a too medical approach will either a) determine that medical practitioners will make all the decisions regarding what is to be funded or not, or b) biomedicine will be the benchmark for these

		decisions. Under NHI, service users should have the right to a second opinion. In terms of the existing Patient Rights Charter, users have the right to "Choose their own health care provider or health facility" and "Be referred for a second opinion to a healthcare professional of their choice." Research shows that where service users participate in decisions made about their care adherence, compliance, and mental health outcomes are improved.
7.5 (a) – (d)	… provide the user with a reasonable opportunity to make representations in respect of such a refusal; *(c)* consider the representations made in respect of paragraph *(b)*; and *(d)* provide adequate reasons for the decision to refuse the health care service to the user.	The average South African is unlikely to be in a position to make representation to the Fund, raising ethical and human rights concerns. Legal opinion should be sought before inclusion of (d), as the board or its medical representatives would need to make these judgments based on other health professional reports, not on direct assessment of the patient, potentially a source of malpractice, and suing of the Fund (high risk approach).

CHAPTER 3: NATIONAL HEALTH INSURANCE FUND

General remarks

- There is overall a worrying amount of centralisation of power and decision-making and diminished service user autonomy, in the manner in which the Fund has been conceptualized. We hope that the Fund does not create an unwieldy, cumbersome, inaccessible, bloated bureaucracy which even further disconnects users from informed decision making around their own health-care needs.
- It is essential that research, monitoring and evaluation of the impact of the Fund on national health outcomes include mental health indicators, and include psychology professionals registered with the HPCSA in the conceptualization, design and implementation of such studies.

Section	**Comment/ Proposed changes (underlined)**	**Justification for change**

<table>
<tr><td>13 (5) (b)</td><td>(b) have appropriate technical expertise, skills and knowledge or experience in health care service financing, health economics, public health <u>programme development and</u> planning, monitoring and evaluation, law, actuarial sciences, information technology and communication.

It is recommended that the Board include a public mental health specialist (S 13.5b) given its wide-ranging powers and functions (S 15).</td><td>Care should be taken to include expertise of the actual mental and physical health programme development and implementation. Health committees tend to include support expertise (finance, M&E, IT, ICT, etc.) with much less attention to the goodness of fit of these with the actual programmes (interventions) delivered to users.

Also, unlike other priority health programmes (e.g., TB dots, HIV, eye care, etc.) there are no national mental health programmes specifically developed and implemented in our local context at the present time. These should be developed.</td></tr>
<tr><td colspan="3">CHAPTER 5:
General remarks:
It is essential that the appointment of the CEO be a person with impeccable moral integrity, exceptional technical expertise in managing such a large Fund, and has the necessary emotional intelligence to be a transformative leader. This will ensure greater public buy-in, confidence, and trust in the NHI. Stringent accountability mechanisms and measures will need to be explicated for this post.</td></tr>
<tr><td>20 (e)</td><td>establishment of an Investigating Unit within the national office of the Fund for the purposes of— (i) investigating complaints of fraud, corruption, other criminal activity, unethical business practices and abuse relating to any matter affecting <u>payees or</u> users of the Fund; and (ii) liaising with the District Health Management Office concerning any matter contemplated in subparagraph (i)</td><td>The fund cannot investigate itself. Therefore the fund must be subject to the same external scrutiny that any other public structure is subject to under the law. Internal audit and forensic services within many SOEs did not prevent the widespread depredation of public resources.</td></tr>
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CHAPTER 6:

General remarks:

- Given that, unlike physical health care, programmes, benefits and equipment for mental health care, and psychological care within this ambit, are still poorly explicated, it would be advisable to convene a Psychological Services Technical Committee to advise the Board. If a broader Mental Health Technical Committee is established instead, it is essential that *practising* psychologists in registration categories involved in delivering quality health care services should be are included in this Committee. PsySSA is willing to engage in this and other such matters where expertise may be sought.

CHAPTER 7:

General remarks:

- All Advisory Committees must include mental health specialists, such as psychologists.
- The Benefits Advisory Committee is a pivotal and powerful decision-making body and needs wide representation, including mental health specialists, such as psychologists, to ensure that the services purchased by the Fund include comprehensive cover for all relevant psychotherapeutic and psychosocial treatments.
- Greater clarity is needed on the Stakeholder Advisory Committee, i.e. the minimum number of members, frequency of meetings, mechanisms of communication, and its roles and functions.

Section	Comment/ Proposed changes (underlined)	Justification for change
25 (2)	The membership of the Benefits Advisory Committee, appointed by the Minister, must consist of persons with technical expertise in medicine and allied health professions, public health and mental health, health economics, epidemiology, and the rights of patients, and one member must represent the Minister.	As motivated on page 1 and 2, in particular comment 2.3 on the SAHRC report on the status of mental health services in South Africa, there is a need for explicit mention of mental health in the Bill given the tendency to focus on physical health and neglect of mental health in the development of healthcare strategies (despite national policies for inclusion), and the mental health focus of the SGDs, WHO recommendations and mGAP.
26 (2)	(2) The Health Care Benefits Pricing Committee consists of persons with expertise in actuarial science, medicine and allied professions, epidemiology, health management, health economics, health financing, labour and rights of patients, and one member must represent the Minister.	Medical practitioners cannot be expected to provide adequate input on decisions which impact on other categories of health professionals, such as psychologists.

27	**27.** The Minister must, after consultation with the Board and by notice in the *Gazette*, appoint a Stakeholder Advisory Committee comprised of representatives from the statutory health professions councils, health public entities, organised labour, civil society organisations, associations of health and mental health professionals and providers as well as patient health and mental health advocacy groups in such a manner as may be prescribed.	As per the above two justifications.

CHAPTER 8:
General Remarks

- Given the extensive role of the National Department of Health, it is essential that mental health be kept on the agenda and psychology professionals registered with the HPCSA be called up to advise on their functions e.g. such as in issuing and promoting guidelines for norms and standards related to health matters (S 32a) or planning the development of public and private hospitals (S 32d). It is often the case that psychological services are not catered for by design, and this can be prevented by including psychology professionals registered with the HPCSA in formative discussions from the outset. This is particularly important given the priorities noted on page 2-3 of our submission.

Section	**Comment/ Proposed changes (underlined)**	**Justification for change**
31 (2) Chapters 4-6	(2) The Minister must clearly delineate, in appropriate legislation, the respective roles and responsibilities of the Fund and the national and provincial Departments, taking into consideration the Constitution, this Act and the National Health Act, in order to prevent duplication of services and the wasting of resources and to ensure the equitable provision and financing of health services. A mechanism (high level task team) must be established in the Ministers office during phase I to assist the Minister to effect section 31 (2).	It is of concern that the Minister of Health, as an individual, is at the epicenter of most decision-making regarding the Fund, and will wield an inordinate amount of discretionary power over the entire health care system in South Africa. Despite the checks and balances put in place to curb the abuse of power and/or the dangers of state capture seen in so many recent political appointments, it is essential that more impactful mechanisms be written into the Bill so that related advisory committees and civil society more broadly can influence Ministerial decisions. A burgeoning developmental state underpinned by democratic decision-making deserves no less. The provisions for the establishment of the Fund Board, Fund management and employees, and infrastructure is extensive and

		likely to utilize a substantial portion of the health budget intended for health services for citizens. The comment already made above about learning from other jurisdictions, such as the UK NHS, and their bloated bureaucracies and the extant top-heavy bureaucracy in our country should provide sufficient evidence in this regard. There is a need to explicate the mechanisms which the Minister will use to address the matter of expenditure control of the Fund.
32	(a) issuing and promoting guidelines for norms and standards related to health matters;	Guidelines need a clear and distinct timeframe. The need for review of and implementation of norms and standards in the field of mental health has been communicated to National DOH over the years with no outcome. The lack of *appropriate* norms and standards has serious implications for staffing and budgets, which negatively affects service provision.
32	(b) implementing human resources planning, development, production and management;	The recommendations of the National Mental Health Policy (2013-2020) regarding the development of human resources and programmes for psychological services have reference. The underfunding of posts (mostly allied health- including psychologists- and admin support) requires attention to address the unmet mental health burden, even at this time when government seeks to curtail excessive spending on public service posts
33	Once National Health Insurance has been fully implemented as determined by the Minister through regulations in the *Gazette*, medical schemes may only offer complementary cover to services not reimbursable by the Fund, except in circumstances where a complementary list has been approved by the Minister permitting formulary services to be provide by private health schemes where this support may be in the best interests of users of services, and to promote public-private partnerships.	This shows a more systemic problem, whereby the role of medical schemes needs far greater clarity given that many health practitioners (including the majority of psychologists, given the scarcity of public service posts) work in private practice and rely on medical schemes for their income. The Department needs to be far clearer on the real-world implications of this on private health professionals and service users, to curb the fear, anxiety and paranoia about future employment opportunities in South Africa, especially at a time when such services are sorely needed. To prevent a massive brain-drain, the Department needs to clearly stipulate, early on, how the NHI Bill will impact income-generation, employment, and private practice. During the establishment of the

		NHI, it would be useful for legislation to permit some flexibility in utilization of the country's full complement of services providers, to ensure that public and private service provision is supportive of access for users, and that no unnecessary service gaps arise during the "teething" period of the new system. Otherwise if health care practitioners are not accredited – they will effectively be unable to work as the Fund will eventually cover most aspects of health care. The suggested amendment would provide the Minister, and the Fund with the necessary flexibility in the first period of implementation of the new system, and to better explore options for public private mix, as required in section 37 (2) (h)
34	National Health Information System	There are many public hospitals and clinics that have limited or no access to email or intranet. Without concerted effort in line with proper infrastructure, these systems will fail before they have even started. Remote provision of scarce services which relies on such technology in the 4IR era needs such necessary infrastructure and must be a necessary adjunct to the NHI system in our country. The National Health Information System (S 34.1) must include comprehensive mental health indicators
35.1	Diagnosis Related Groups	Psychologists and other mental health professionals must be included to provide inputs relating to mental health Diagnostic Related Groups. The purchasing of health care services, if it is to be active and strategic, must consider the DALYs caused by mental illnesses and related burdens of disease. As it is currently stated, "*in accordance with need*" raises questions of definition: how is "*need*" determined and who determines this? Emergency medical services (mentioned in S 35.4a) must include psychiatric and psychological emergencies, such as suicidal- or

		homicidal ideation, aggressive behaviour, substance misuse, and psychosis; all of which are at critical levels in South Africa.
37	Health promotion & prevention – funding and provision	It is unclear how health promotion and prevention needs will be determined. Given the lack of public awareness regarding mental health, and the ongoing stigma experienced by service users with mental illness, psychologists and other mental health professionals need to be actively involved in determining health promotion and prevention needs and programmes. Registered counsellors can also contribute enormously to the provision of mental health promotion and prevention and should be effectively utilised in the public health care system as originally intended in the conceptualization of this category of health professional.
Office of Health Products Procurement S38	(4) The Office of Health Products Procurement must support the Benefits Advisory Committee in the development and maintenance of the Formulary, comprised of the Essential Medicine List and Essential Equipment List as well as a list of health related products used in the delivery of health care services as approved by the Minister in consultation with the National Health Council and the Fund	What processes can be implemented to review the Formulary and what are the time frames? Inputs from mental health professionals are required in this regard. Psychometric equipment, play therapy equipment, etc. must be included in the Essential Equipment List.
Accreditation of service providers s38	(b) meet the needs of users and ensure service provider compliance with prescribed specific performance criteria, including the—…	This raises questions on how the fund will monitor this. Without clear guidelines, in light of our susceptibility to corruption, this is both inefficient and unethical practice.
38	(4) The contract between the Fund and an accredited health care service provider or health establishment must contain a clear statement of performance expectation and need in respect of the management of patients, the volume and quality of services delivered and access to services	Again, there needs to be clear indication of how the fund will monitor this. Even with a Ministry of Evaluation and Monitoring, there seems to be serious flaws which are opportunistically exploited.
38	(6) The performance of an accredited health care service provider or health establishment must be monitored and evaluated in accordance with this Act and appropriate sanctions	This must be done by an independent body, such as the HPCSA and/or OHSC.

	must be applied where there is deviation from contractual obligations as per the law.	
38	(8) The Fund may withdraw or refuse to renew the accreditation of a health care service provider or health establishment if it is proven that the health care service provider or health establishment, as the case may be— (a)has failed or is unable to deliver the required comprehensive health care service benefits to users who are entitled to such benefits; (b) is no longer in possession of, or is unable to produce proof …	This does not take into account the unique governance of profession specific, occupation-bound scope of practice. Accreditation needs to be facilitated by health care practitioners in that specific clinical discipline – it does not make sense to have (for example) a medical practitioner accrediting a psychologist.
38(3)	The Office of Health Products Procurement	The Office of Health Products Procurement (S 38) must be incorruptible given the centralised public procurement of health products. A set of essential psychological assessment tools for use in both general mental health service settings, and forensic mental health settings will be required and should be included in the Office of Health Products Procurement's selection of health-related products to be procured for the Essential Equipment List. PsySSA, is willing to inform this process, as is the case in other areas where our knowledge, skills, experience and expertise may be required. Psychology professionals registered with the HPCSA to be included (advisory capacity, contracted member to the Office of HPP) to ensure adequate inclusion of required assessment tools on the Essential Equipment List and within procurement processes. Child Intervention equipment must be included in the national health products list (S 38.3b).

39 (6)		Greater clarity is needed on how accredited health care service providers or establishments will be monitored and evaluated. It is recommended that appropriately skilled and knowledgeable clinically appropriate psychologists with expertise in public mental health be considered key stakeholders or preferred candidates for the appointment of such monitoring roles. PsySSA is willing to advise and serve on an independent non-conflicted adjudication panel for this purpose.
40	(c) the information is required by an accredited health care service provider, health establishment, <u>supplier or researchers</u> for the lawful purpose of improving health care practices and policy, but not for commercial purposes.	This immediately raises serious ethical concerns on informed consent. How will the Fund ensure ethical, independent and methodologically rigorous research?
41	Review of the payment of health care service providers.	It is essential that payment of health care service providers be on par or exceeds current levels of reimbursement to prevent further brain- drain (of public-funded and trained skilled health providers) and promote the wellbeing and retention of health professionals able to provide appropriate services to the larger majority of our citizens.
41(3)(b)	"… in the case of <u>health care service provider</u> and hospital services, payments must be all-inclusive …"	This statement must refer to all relevant practitioners.
42	(2) The Investigating Unit established by the Chief Executive Officer in terms of section 20(2)(e) must launch <u>an investigation to establish the facts of the incident reported and must make recommendations</u> to the Chief Executive Officer as to the way in which the matter may be resolved within 30 days of receipt of the complaint. This investigating unit must be a separate body – otherwise it will cause severe ethical issues around transparency.	The Fund cannot investigate itself. This opens up the possibility of corruption in the absence of transparency.
CHAPTER 9, 10: No specific comments		

CHAPTER 11:
No specific comments

Section	Comment/ Proposed changes (underlined)	Justification for change
55.1 (e)	Clinical information and diagnostic and procedure codes to be submitted and used by health care service providers, health establishments or suppliers for reimbursement and reporting purposes to the Fund, <u>based on internationally accepted diagnostic and procedural codes, and compatible with the national health information system and the Health Patient Registration System</u>	The ICD-11 codes are suggested (WHO's earliest date for usage is January 2022), and any subsequent revising thereof.
57.2 (iv)	Include the purchasing of personal health care services for vulnerable groups, but given the intersectional nature of vulnerability, this list can and should be expanded to include children, women, refugees, LGBTI+ people, people living in deep rural areas, people with <u>mental and physical</u> disabilities and the elderly;	As motivated on page 1 and 2, in particular comment 2.3 on the SAHRC report on the status of mental health services in South Africa, there is a need for explicit mention of mental health in the bill given the tendency to focus on physical health- and neglect mental health - in the development of health strategy (despite national policies for inclusion).
57.3(b)	*(b)* The National Governing Body on Training and Development which must, amongst others— (i) be responsible for advising the Minister on the vision for health workforce matters, for recommending policy related to health <u>and relevant social</u> sciences, student education and training, including a human resource for health development plan; (ii) be responsible for the determination of the number and placement of (including but not limited to) all categories of interns, community service and registrars; (iii) oversee and monitor the implementation of the policy and evaluate its impact; and (iv) coordinate and align strategy, policy and financing of health <u>and relevant science, including relevant social science education.</u>	Health and mental health services are multidisciplinary, as noted elsewhere in the Bill. The current focus on health science education (doctors, physiotherapists, occupational therapists, nurses) education should be expanded to include all clinicians involved in health services. Review of the education and training of and human resource planning should include social workers and psychologists who are primarily trained in social science not health sciences faculties. This will be essential given the Bill's focus on evidence-based interventions and practice.
57.3(c) and (d)	<u>Mental health representation is requested on the following preliminary committees in phase 1:</u> "The Ministerial Advisory Committee on Health Care Benefits for National Health Insurance, which must be a precursor to the Benefits Advisory	Specialised mental health (including psychology input will be required for deliberations of the Ministerial Advisory Committee on Health Care Benefits (later the Benefits Advisory Committee), the Committee on Health Technology Assessment (later the Health

	Committee and which must advise the Minister on a process of priority-setting to inform the decision-making processes of the Fund to determine the benefits to be covered. *(d)* The Ministerial Advisory Committee on Health Technology Assessment for National Health Insurance, which must be established to advise the Minister on Health Technology Assessment and which must serve as a precursor to the Health Technology Assessment agency that must regularly review the range of health interventions and technology by using the best available evidence on cost-effectiveness, allocative, productive and technical efficiency and Health Technology Assessment"	Technology Assessment agency), to ensure that benefits include appropriate mental health /psychological assessments, interventions and equipment, and can advise regarding development of appropriate and necessary inclusions where they may as yet not be available. Our motivation on page 1 notes PsySSA's willingness to provide research and expert technical input to these processes.
57.4 (f)	the purchasing of health care service benefits, which include personal health services such as primary health care services, maternity and child health care services including school health services, health care services for the aged, people with mental and physical disabilities and rural communities from contracted public and private providers including general practitioners, audiologists, oral health practitioners, optometrists, speech therapists, registered counsellors and psychologists and other designated providers at a primary health care level focusing on disease prevention, health promotion, provision of primary health care services and addressing critical backlogs…	Re: mental and physical disabilities: As motivated on page 1 and 2, in particular comment 2.3 on the SAHRC report on the status of mental health services in South Africa, there is a need for explicit mention of mental health in the bill given the tendency to focus on physical health- and neglect mental health - in the development of health strategy (despite national policies for inclusion). A recent (July 2019) call for expression of interest in inclusion in a national database to provide mental health and forensic services published by the national directorate for mental health, called for submissions by registered counsellors and clinical psychologists. Similar services will be needed within the NHI Fund. We recommend the inclusion of psychology professionals registered with the HPCSA in this section, and all other sectors where health service providers are specifically mentioned by occupational group. Documentation relevant to the registration of psychology professionals is obtainable on the website of the HPCSA Board of Psychology website (policies and guidelines, and rules and regulations). https://www.hpcsa.co.za/?contentId=0&menuSubId=52&actionName=Professional%20Boards

		While all categories of psychology professionals have relevance in various service settings, we make specific mention of the category of "registered counsellor" a 4-year trained health professional specifically created in 2000 to make available psychological services at the primary health care level, a post category already on the human resource establishment of the health sector, but not utilised for post creation. These professionals can offer low-intensity psychological interventions and assessment to individuals and groups within community settings to prevent and alleviate psychological challenges and /or enhance psychological functioning and wellbeing.
4.3 (Memorandum)	4.3 There will be an increased emphasis on health promotion and preventive services, in addition to improving curative and rehabilitative services, <u>and promoting an intersectoral enabling environment for health in a Whole of Society approach</u>	The Bill prioritises people with disabilities, and we recommend *specifically disaggregating "disability" as "mental and physical disability*" (in line with the SDGs emphasis on both). The Bill must recognize that people with disabilities do not only require curative and rehabilitative services, but health promotion and (secondary) prevention supports to enable optimal return to health and community participation. This is recognized in the SAHRC report on mental health services which notes the need for the NHI to consider the funding of community based services outside of the clinic setting as part of a holistic approach to promoting health and mental health. (pg. 22): "NHI includes mental health as part of the package of 'comprehensive health services'. The NDOH has targeted 2026 for the full implementation of the NHI scheme. …It is a concern that the 2017 National Health Insurance White Paper does not currently make allowance for community-based care of MHCUs. This appears to be inconsistent with the NHMPF, which refers to norms and standards for psychiatrists, psychologists, psychiatric nurses and allied professionals developed for community-based mental health care services".

		The report additionally recommends the following national actions: • NDOH should organize a meeting with all key stakeholders involved in mental health including Health, Social Development, Education, Housing, Corrections, Treasury and Labour to establish an interdepartmental standing committee on mental health that meets at least on a quarterly basis if not more frequently.(It would be useful to include an external professional component to avoid our recent history of such stakeholder meetings remaining bureaucratic and not finding traction in meeting the increasing needs of our complex society) • NDOH should appoint a permanent advisory body within the department whose role it is to monitor the observance of human rights in mental health service provision. • Establish a more comprehensive mental health information system. • Assess the public mental health system's ability to cater to the needs of children and adolescents with psychosocial disabilities: Such an assessment should detail the exact number of minors considered MHCUs and exact information to ensure that: children and adolescents with intellectual and psychosocial disabilities and mental conditions are no longer admitted to adult wards; and oversee systemic changes to current health infrastructure to guarantee the availability of community-based child and adolescent mental health services managed by stakeholders that include their caregivers, school and community. And in most provinces, "In consultation with the NDOH, develop a plan for the revitalization of forensic and non-forensic mental health infrastructure in the province which have been historically under-prioritized. Including details on budget and specific measures taken to realise a rights-based approach"

		It is recommended that the provisions of the Bill be updated to include consideration of the above. The recommended national advisory body should be consulted, or if not yet constituted permanently as recommended, the Minister should designate a committee to inform the NHI regarding mental health related components of the Bill as a matter of urgency, to be compliant with the SAHRC report.
General Issues Outside of Specific Chapters		
	Some practitioners provide mental health services in several geographical areas	How would this be dealt with under NHI? This needs to be carefully planned in order to hold to the original ethos of care for all. This includes clarity on m-health applications of mental health services (e.g. remote consultations and online delivery of therapeutic services)
	Administrative support to manage the mandate	Massive administrative support will be required to manage the mandate of the NHI. This needs to be incorporated within the planning, as cutting corners at this stage of planning will have serious ramifications at implementation.
	Training bodies (registrars and interns)	It is unclear how NHI will co-operate with training institutions/universities where interns/registrars provide health care services across a range of settings from tertiary care to primary health care.
	Absence of deliberations around the cooperation with Traditional Healers and African centric knowledge systems. We know that the majority of rural care is performed by these groups.	The Bill does not recognize the need to co-operate with Traditional Healers and does not seem to consider African knowledge systems and their utilization at all.
	Provincial health departments	The role of the Provincial DOH is unclear under NHI.
	Forensic mental health services	These consist of forensic mental health examinations in terms of sections 77 and 78 of the Criminal Procedure Act; assessments of children in conflict with the law in terms of section 11 of the Child Justice Act; survivor competency examinations; pre-sentencing assessments as well as forensic rehabilitation services of State

		Patients. These services require special provisions under NHI – particularly with regard to the provision of recovery based psychosocial rehabilitation to state patients.
	Gender binaries - wording	Within our diverse landscape, the wording of the document should recognize gender fluidity.
	Specific focus on trans and gender-diverse individuals in regards to mental health care.	Access to healthcare is a basic human right and is upheld in the South African Constitution. Furthermore, discrimination against people due to their gender and gender identity is against the Constitution (Republic of South Africa, 1996). In South Africa transgender and gender-diverse people have been struggling to access gender affirming healthcare (Wilson, Marais, De Villiers, Addinall, & Campbell, 2014). Currently there are only two trans- specific clinics in South Africa (Wilson et al., 2014) and unequal access to health, due to social and class inequality, exist. Healthcare providers are generally not trained in gender affirming healthcare and often trans healthcare is not seen as a necessity. Social stigma and transphobia also play a role in these challenges. Trans and gender-diversity is an umbrella term for people whose gender identity is different from their sex assigned at birth and/or express their gender and gender-role in non-traditional ways (World Health Organisation, 2015). In order for them to live authentically, trans and gender-diverse people must be able to access gender affirming healthcare (McLachlan, 2018). Gender affirming healthcare could include social transitioning (where the person expresses their gender identity through for example the way they dress), the use of hormone replacement therapy and gender affirming surgery (WPATH, 2010). For trans and gender-diverse people being able to live their inherent gender identity in society and having access to gender affirming

		healthcare have been found to improve their mental health and lower suicide risk (Koch, McLachlan, Victor, Westcott & Yager, 2019). PsySSA (2017) released affirmative guidelines for psychology professionals working in this field. These guidelines are also trans- and gender-diverse affirmative and support the notion that all trans and gender-diverse people need to be able to access gender-affirming healthcare (McLachlan, Nel, Pillay & Victor, 2019). Hormones are already included in the National Health Department's Essential Medicine List. Adequate psychological support is essential as the person accesses gender- affirming healthcare. Furthermore, training in gender affirming healthcare becomes essential for healthcare providers, psychologists and social workers.
	It must include a section on the establishment of an oversight body without vested interests, constituted of representatives from professional and civil groups, including those with finance and accounting expertise.	The "*Stakeholder Advisory Committee"* detailed in section 27 does not address this as it is an "*advisory*" committee and will, therefore, be toothless.
	Include a section on the appointment of an Ombudsperson.	The Bill makes no mention of an Ombudsperson to represent the interest of the public at a level removed from the Fund and the Minister. Will the current Health Ombudsperson have authority in the NHI? If so, this should be indicated in the Bill.
	Section (38) "*Office of Health Products Procurement*" should include a provision for an oversight mechanism/body to prevent the past and present day fraudulent activities.	Section (38) does not include a provision to prevent tender fraud and other criminal activities that have plagued government department procurement processes. This point is crucial to repairing the lost trust between the general public and the integrity of Government. Therefore, instruments are needed to assure the public accordingly and ensure that the NHI funds will be used in an honest manner.

Conclusion

PsySSA is excited at the prospect of healthcare for all, which the NHI proposes.

However, with the difficulties in implementation of previous documentation and policies (e.g. Mental Health Framework 2013-2020), trust has been broken between the demands of delivery of a system overhaul and provision of resources necessary to sustain it. We hope to become active social actors dedicated to promoting mental health in an often traumatized society.

We quote the Preamble and Principle of the PsySSA Constitution:

We acknowledge psychology's historical complicity in supporting and perpetuating colonialism and the apartheid system, and mindful of the history and principles underlying the Constitution of the Republic of South Africa, we commit ourselves to:

1. Transforming and redressing the silences in South African psychology to serve the needs and interests of all South Africa's people;
2. Developing an organizational structure for psychology that reconciles historically opposed groups, gives a voice to hitherto excluded users of psychological knowledge and skills, and ensures transparent accountable governance of the Society to serve the democratically expressed wishes of its membership;
3. Ensuring that the Society remains an organ of civil society without an overt or covert loyalty to any political party;
4. Advancing psychology as a science, profession and as a means of promoting human well-being;
5. Actively striving for social justice, opposing policies that deny individuals or groups access to the material and psychological conditions necessary for optimal human development, and protesting against any violations of basic human rights;
6. Promoting rigorous research and encouraging the application of research findings in the advancement of public well-being;
7. Establishing and maintaining the highest standards of ethics, conduct and lifelong education of psychologists;
8. Engaging in policy development processes that are relevant to social enhancement and psychological practice in South Africa;
9. Promoting the rendering of and advancing mental health services to all in South Africa.

END OF DOCUMENT