South African Society of Psychiatrists

Unit 16, Northcliff Office Park
203 Beyers Naude Drive
Northcliff, 2115
Tel: (+27)(11) 340 9000
Fax: (+27)(11) 782 0270
Email: info@healthman.co.za
PO Box 2127,
Cresta, 2118
Registration No.: 2007/012757/08

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Attention
Chairperson: Portfolio Committee on Health
Dr Sibongiseni Dhlomo,

Per address
Ms Vuyokazi Majalamba (Secretary Portfolio Committee on Health)
email: vmajalamba@parliament.gov.za

Dear Dr Dhlomo and Portfolio Committee on Health

SASOP SUBMISSION IN RESPONSE TO NHI BILL

1. The South African Society of Psychiatrists (SASOP) was established in 1952 and is currently a non-profit company incorporated according to Companies Act, Act No. 71 of 2008, Reg. no. 2007/012757/08. The society is actively involved in de-stigmatising mental illness both locally and internationally, and in the fight against discrimination against people who suffer from mental illness. The SASOP is managed by a team of psychiatrists who are elected volunteers. Elections take place biennially at the biennial national psychiatry congress.
2. The main objectives of the Society are to:
    - promote and protect the rights and interests of the members of the Society
    - foster good relationships among the members of the Society
    - promote cooperation with other associations involved in mental health
    - monitor, evaluate and advise on policies related to the delivery of clinical services and the protection of patients' rights
    - promote research appropriate to Psychiatry in South Africa
    - promote appropriate training and evaluation of standards of undergraduate and postgraduate students in Psychiatry
    - promote continuing education in Psychiatry
    - maintain standards in Psychiatry by peer review
    - promote and uphold the principles of human rights, dignity and ethics in the practice of Psychiatry
    - oppose unfair discrimination in the field of Psychiatry
    - promote the de-stigmatisation of Psychiatry and increase the awareness of mental illness

- promote the academic status of Psychiatry as one of major clinical disciplines in all schools of clinical medicine in the different South African universities, in collaboration with the different appointed heads of academic departments.
- act as a lobby group to further the interest of the discipline of Psychiatry in both the public and private sectors.

3. In light of the objectives of SASOP, and SASOP being the only representative body for psychiatrists in South Africa, representing approximately 75% of psychiatrists working in South Africa, we are grateful to have this opportunity to respond to the NHI Bill which was published on 9 August 2019. SASOP is in favour of any Health Policy initiatives which will provide access to Universal Health Coverage and improve access to Mental Healthcare services for South African patients.

4. This response is primarily concerned with the NHI Bill as it relates to the provision of mental health care from a clinical, services delivery perspective. Therefore, such matters are only discussed in this document where they are of general concern to all SASOP members and South African Mental Healthcare users.

5. The vast majority of people with mental illness in South Africa currently do not receive treatment of any kind[1,2]. However, mental illness has significant public health and social implications. [3,4,5] As with all measures that will close the treatment gap for the mentally ill, SASOP fully supports the integration of mental health into primary care. Mental illness is closely linked to poverty as it often leads to unemployment and poor socio-economic circumstances for the individual sufferer and their families[2,5]. A consequence of this is that the severely mentally ill, already a marginalised group in society, are unable to access health care which requires employment-linked insurance or out of pocket payment. [6] They are thus dependent on the public health sector for mental health care. We therefore commend and support the Honourable Minister of Health, Dr Mkhize, in his endeavours to achieve equal access to quality care for all South Africans. We hope that we may be of service in reaching this goal. Our comments on the NHI Bill are made in this light.

Background: Mental Health as a Public Health Priority

6. Mental illness as a public health priority in South Africa cannot be overemphasised. South Africa reportedly has the highest disease burden per capita of any middle income country, with four "colliding epidemics" of disease: HIV and tuberculosis; maternal, neonatal and child health; non-communicable diseases (NCDs) and mental illness, and fourthly, violence and injury[7]. However, the role of mental illness in the overall burden of disease is such that it should be considered as much more than just one of the NCDs. Firstly, it is highly co-morbid with and worsens treatment outcome of the other NCDs.[3] Secondly, mental illness and substance use disorders are interwoven into each of the other epidemics in terms of both cause and effect. Thirdly, mental

[1] Williams DR, Herman A, Stein DJ, Heeringa SG, Jackson PB, Moomal H, et al. Twelve-Month Mental Disorders in South Africa: Prevalence, Service Use and Demographic Correlates in the Population-Based South African Stress and Health Study. Psychol Med. 2008;38(2):211-20.

[2] DOH. National Mental Health Policy Framework and Strategic Plan 2013 - 2020. Pretoria: Government of South Africa; 2012.

[3] Prince M, Patel V, Saxena S, Maj M, Maselko J, Phillips MR, et al. No Health without Mental Health. Lancet. 2007;370(9590):859-77.

[4] Patel V, Flisher AJ, Hetrick S, McGorry P. Mental Health of Young People: A Global Public-Health Challenge. Lancet. 2007; 369(9569):1302-13.

[5] Lund C, De Silva M, Plagerson S, Cooper S, Chisholm D, Das J, et al. Poverty and Mental Disorders: Breaking the Cycle in Low-Income and Middle-Income Countries. Lancet. 2011;378(9801):1502-14.

[6] Dixon A, McDaid D, Knapp M, Curran C. Financing Mental Health Services in Low- and Middle-Income Countries. Health Policy Plan. 2006;21(3):171-82.

[7] Mayosi BM, Lawn JE, van Niekerk A, Bradshaw D, Abdool Karim SS, Coovadia HM, et al. Health in South Africa: Changes and Challenges since 2009. Lancet. 2012;380(9858):2029-43.

illness and substance use disorders are the leading cause of years lived with disability (YLD) worldwide[8]. The onset of mental illness is most commonly in youth with persistence into later life. It causes significant functional impairment and behavioural problems. When poorly treated, the ensuing severe social and occupational disability is often lifelong and entrenches poverty.[9] A breakdown of the Global Burden of Disease (GBD) Study 2010 for South Africa[10] reveals mental illness and behavioural disorders to be the leading cause of disability between the ages of 10 – 29 years, superseded by HIV/AIDS after the age of 30 years.[11]

7. The impact of mental illness during childhood and adolescence is of grave concern in South Africa, given the high prevalence of health risk behaviour amongst our youth[12] and that it predisposes to school failure. [13] In addition, the behavioural, substance use and socio-economic problems associated with mental illness all predispose an individual to HIV infection. [14] In turn, HIV infection causes and exacerbates mental illness and neurocognitive disorders. These then worsen treatment outcomes of HIV/AIDS.[15] It is therefore not known to what extent the high level of disability due to HIV/AIDs between the ages of 30 and 44 years is related to the HIV infection itself, mental illness and neurocognitive disorders secondary to HIV infection, or to co-morbid mental illness and behavioural problems which preceded HIV infection.

8. The impact of mental illness on maternal, neonatal and child health has been well-documented in the Lancet Series on Perinatal Mental Health[16] and the Lancet Global Mental Health Series.[17] Maternal mental illness is associated with an increased rate of poor maternal and foetal outcomes of pregnancy and poor infant growth (specifically in low and middle income countries (LMICS)). Mental illness in a parent is associated with an increased incidence of hospital admissions and emergency room visits as well as with mental illness and behavioural disorders in their children. Comorbid substance use disorders and medical illnesses such as HIV/AIDS compound the negative effects of maternal mental illness. Therapeutic interventions in mentally ill parents have been shown to reduce mental illness and behavioural problems in their offspring by up to 40%.[18] Although the evidence base is limited, the neglect of maternal mental health care cannot be justified.

9. Deaths due to interpersonal violence are ranked third in terms of premature mortality in South Africa[10] and contribute to the fourth epidemic: violence and injury. Interpersonal violence, mental illness and substance use disorders are inextricably linked. Not only does violence contribute to the development of mental illness,

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[8] Whiteford HA, Degenhardt L, Rehm J, Baxter AJ, Ferrari AJ, Erskine HE, et al. Global Burden of Disease Attributable to Mental and Substance Use Disorders: Findings from the Global Burden of Disease Study 2010. Lancet. 2013;382(9904):1575-86.

[9] Patel V, Flisher AJ, Hetrick S, McGorry P. Mental Health of Young People: A Global Public-Health Challenge. Lancet. 2007; 369(9569):1302-13

[10] Institute for Health Metrics and Evaluation. Gbd Profile: South Africa. Global Burden of Diseases, Injuries and Risk Factors Study 2010. Seattle, Washington, USA2010

[11] Whiteford HA, Degenhardt L, Rehm J, Baxter AJ, Ferrari AJ, Erskine HE, et al. Global Burden of Disease Attributable to Mental and Substance Use Disorders: Findings from the Global Burden of Disease Study 2010. Lancet. 2013;382(9904):1575-86.

[12] Reddy SP, James S, Sewpaul R, Koopman F, Funani NI, Sifunda S, et al. Umthente Uhlaba Usamila - the South African National Youth Risk Behaviour Survey 2008. Cape Town: Medical Research Council of South Africa; 2010.

[13] Myer L, Stein DJ, Jackson PB, Herman AA, Seedat S, Williams DR. Impact of Common Mental Disorders During Childhood and Adolescence on Secondary School Completion. S Afr Med J. 2009;99(5 Pt 2):354-6.

[14] Hobkirk AL, Towe SL, Lion R, Meade CS. Primary and Secondary HIV Prevention among Persons with Severe Mental Illness: Recent Findings. Curr HIV/AIDS Rep. 2015;12(4):406-12.

[15] Blank MB, Himelhoch S, Walkup J, Eisenberg MM. Treatment Considerations for HIV-Infected Individuals with Severe Mental Illness. Curr HIV/AIDS Rep. 2013;10(4):371-9.

[16] Howard LM, Piot P, Stein A. No Health without Perinatal Mental Health. Lancet. 2014;384(9956):1723-4.

[17] Prince M, Patel V, Saxena S, Maj M, Maselko J, Phillips MR, et al. No Health without Mental Health. Lancet. 2007;370(9590):859-77.

[18] Siegenthaler E, Munder T, Egger M. Effect of Preventive Interventions in Mentally Ill Parents on the Mental Health of the Offspring: Systematic Review and Meta-Analysis. J Am Acad Child Adolesc Psychiatry. 2012;51(1):8-17 e8.

people with mental illness are more likely to be victims of violence than the general population and may be more likely to be perpetrators of violence.[19,20] In addition, links have been made between mental illness, substance use disorders, interpersonal violence and the contraction of sexually transmitted infections (STIs) and HIV/AIDS.[21] We believe that any attempts to reduce the levels of interpersonal violence must contain methods of addressing mental illness and substance use in the community.

10. It must be remembered that the term "mental illness" may be applied to a range of psychological and psychiatric disorders which require a variety of interventions.[22] Conduct and personality disorders, which may cause serious behavioural disturbance, are particularly difficult to address. They require the involvement of non-health sectors such as education, social development, the police, justice and correctional services. The role of mental health professionals is therefore not necessarily to treat but often to provide specialist assessment, input and advice to primary health care (PHC), other specialist health care and to non-health sectors regarding the management of problematic behaviour.

11. The SASOP response to the NHI Bill is made against this background of the public health significance of mental illness and improving access to mental healthcare services for all patients in South Africa. In particular, we advocate for the incorporation of Community Psychiatry into NHI, according to the requisites of the National Mental Health Policy Framework and Strategic Plan 2013 – 2020 (NMHPF).[23] We would also like to see a Mental health care environment where patients currently confined to the public health system due to their socio-economic situation would also be able to access private mental healthcare services.

12. Two benefits of a comprehensive package of specialist run community mental health care (CMHC) make it an imperative for South Africa:
    a. The prevention of years lived with disability, through the practice of primary, secondary and tertiary preventative psychiatry at the level of the community.
    b. The provision of the basic human right to health care, food, shelter and protection for people living with severe mental illness.
13. It is a known fact that contemplating mental health system scale-up embedded into wider universal health coverage-related health system transformations, require detailed and locally derived estimates on existing mental health system resources and constraints. The absence of these data has limited scale-up efforts to address the burden of mental disorders in most Low and Middle income countries.[24] It is therefore imperative that if South Africa is going to roll out a National Health Insurance model, the current costs of service delivery in both the public and private sector is known, in order to ensure sufficient resources are made available to cover the entire population in this insurance model.

SASOP Service Delivery Proposal

14. SASOP would like to use this opportunity to provide inputs on possible service delivery structures within a National Health Insurance environment. This service delivery model will also be useful in the run-up to full

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[19] [19] Patel V, Flisher AJ, Hetrick S, McGorry P. Mental Health of Young People: A Global Public-Health Challenge. Lancet. 2007; 369(9569):1302-13.

[20] Trevillion K, Oram S, Feder G, Howard LM. Experiences of Domestic Violence and Mental Disorders: A Systematic Review and Meta-Analysis. PLoS One. 2012;7(12):e51740.

[21] Campbell JC. Health Consequences of Intimate Partner Violence. Lancet. 2002;359(9314):1331-6.

[22] American Psychiatric Association DSM-5 Task Force. Diagnostic and Statistical Manual of Mental Disorders : DSM-5. 5th ed. Washington, D.C.: American Psychiatric Association; 2013.

[23] DOH. National Mental Health Policy Framework and Strategic Plan 2013 - 2020. Pretoria: Government of South Africa; 2012.

[24] Docrat S, Mesada D, Cleary S Daviaud E, Lund C. Mental health system costs, resources and constraints in South Africa: a national survey. Health Policy and Planning, 2019, 1–14

NHI implementation. Following the model, we wish to raise specific concerns regarding the NHI Bill in its current format.

15. South Africa has a scarcity of skilled professionals who can deliver psychiatric services to the entire population. According to the World Bank, South Africa has 0.9 physicians per 1000 population, while the world average is 1.5 per 1000 population[25], and 0.5 psychiatrists per 100,000 population with the recommended world average suggested to be 15 per 100,000 population.[26]

16. With scarce professional resources and financial constraints in South Africa, the challenges faced by South Africa to deliver mental healthcare services to all South Africans are numerous. Managing the mental health system optimally would need careful planning and implementation.

17. Currently two sectors serve the psychiatric healthcare needs of all South Africans, a public and a private system. Both these systems have advantages and disadvantages and therefore the best in each system should be retained and the challenges addressed. The envisaged system needs to be efficient, quality driven and sustainable and affordable.

18. To abolish one of the systems in favour of the other has the potential to harm the health sector in its entirety. It would be best to plan a slow transition to better integrate the two systems.

19. The aim of both systems would be to provide the best primary care to patients at all times. Both sectors do not fully succeed in this endeavour as the private sector is hospicentric and specialist driven whilst the public sector was historically inadequate, under-resourced, inequitable and inefficient; the latter due to a bygone hospital centered model.[27] Both these sectors must be supported by Primary Care Practitioners who work in teams where a patient can choose their primary healthcare practitioner who they trust and who will remain responsible for that patient. Patients should not be subjected to seeing a different practitioner every time they visit a practice or a clinic. This reduces the responsibility of practitioners to be accountable for the best care of their own patients.

20. To address these challenges in both sectors a new model is proposed where all providers of healthcare are included in the delivery of services. A model of psychiatric teams should be created with nurses, enrolled nurses and registered nurses delivering basic care with support of General Practitioners with further qualifications in psychiatry. They in turn should be supported by counsellors and clinical and counselling psychologists, occupational therapists, dieticians, physiotherapists, speech therapists and psychiatrists. This model is also broadly aligned and endorsed by the Mental Health Policy Framework as well as the recent SAHRC report which was published in the aftermath of the Life Esidimeni Tragedy.

21. To ensure quality of care, the system should be based on value, where the quality of care is measured through outcomes measures which include measuring symptom relief and functioning which needs to include patient reported outcomes measures (PROMS) and provider reported measures[28]. The cost of care should continuously be monitored with the aim to keep the cost as low as is appropriate. Clinical and financial risk should be assessed through a comprehensive clinical and financial risk management system. Value, defined

[25] https://data.worldbank.org/indicator/SH.MED.PHYS.ZS

[26] Johannes H. De Kock; Basil J. Pillay; A situation analysis of psychiatrists in South Africa's rural primary healthcare settings; Afr. j. prim. health care fam. med. (Online) vol.9 n.1 Cape Town 2017; http://dx.doi.org/10.4102/phcfm.v9i1.1335

[27] Docrat S, Mesada D, Cleary S Daviaud E, Lund C. Mental health system costs, resources and constraints in South Africa: a national survey. Health Policy and Planning, 2019, 1–14

[28] Harding KJ, Rush AJ, Arbuckle M, et al. Measurement-based care in psychiatric practice: a policy framework for implementation. J Clin Psychiatry. 2011;72:1136–1143

as quality over cost should be balanced by also reducing the clinical risk to the patient and the financial risk to the organisation and the funder.

22. Regular multi-disciplinary team meetings with discussion of each case should be organised frequently to ensure peer review of all cases and standardisation of care. Value based care (measurement based care) has been proven in patients with Major Depression to be more effective than in a control group who received care as usual[29] and the standardisation of care has proven to be more cost efficient[30], [31], [32]. Measurement based care has been proven to improve clinical outcomes, inform collaborative care efforts, enhance treatment decision-making processes, and increase client engagement in therapy[33].
23. Patients with co-morbid medical problems should be referred by the nurse to the General Practitioner for care and failing accurate diagnosis or improvement should only then be referred to a psychiatrist or specialist for care. Patients should, as far as possible, be referred to the appropriate ancillary health professionals for psycho-, occupational-, physio-, dietetic- and speech therapy. Patients with co-morbid medical and surgical problems should be referred for the appropriate care to medical and surgical teams to manage the patient, coordinated by the patient's primary physician.
24. The psychiatric team should be based close to the community they serve, and also have access to psychiatric in-patient facilities in close proximity for those patients requiring hospitalisation.
25. Remuneration of services should be to the psychiatric team and not the individual provider and based on performance and the number of patients seen. The better the quality, the higher the number of patients treated, the lower the risk and the cost the higher the fee paid for such a service. This would incentivise the best care and efficiencies.
26. The team should aim to manage adherence to treatment to ensure a low relapse rate, hospitalisation rate and re-admission rate. Once patients have fully stabilised, they should be referred back to their respective primary healthcare team for continued care. Those patients with chronic complicated psychiatric problems should remain under the care of the psychiatric team in collaboration of the primary healthcare team.
27. Value and risk data should be made available to ensure transparency and drive competition as well as higher or lower levels of remuneration. Funders can freely evaluate what they pay for.
28. The system has to be driven by an IT platform (which exists) that captures demographic data, serves as an electronic health record, generates electronic medication prescriptions and measures outcomes and cost and ensures coordination of care[34]. Results of special investigations, including pathology, radiology, neurophysiology and psychometry are automatically imported onto the system to be available to the practitioner. As soon as the outcomes are captured and stored on a central database, it can be analysed in real time and reported. Care can be coordinated in and out of hospital and value can be captured and

[29] Guo T, Xiang YT, Xiao L, et al. Measurementbased care versus standard care for major depression: a randomized controlled trial with blind raters. Am J Psychiatry. 2015;172:1004–1013.
[30] Ricken R, WiethoK, Reinhold T, et al. Algorithm-guided treatment of depression reduces treatment costs--results from the randomized controlled German Algorithm Project (GAPII). J A- ect Disord. 2011;134:249–256.
[31] Trivedi MH, Rush AJ, Crismon ML, et al: Clinical results for patients with major depressive disorder in the Texas Medication Algorithm Project. Arch Gen Psychiatry 2004; 61:669–680 7.
[32] Adli M, Bauer M, Rush AJ: Algorithms and collaborative-care systems for depression: are they effective and why? A systematic review. Biol Psychiatry 2006; 59:1029–1038
[33] Scott K, Lewis CC. Using measurement-based care to enhance any treatment. Cogn Behav Pract. 2015;22:49–59.
[34] Harding KJ, Rush AJ, Arbuckle M, et al. Measurement-based care in psychiatric practice: a policy framework for implementation. J Clin Psychiatry. 2011;72:1136–1143.

analysed at all service delivery levels. Demographic, clinical and treatment data is available to all team members at any given time, anywhere, to assist with care of the patient.

29. To ensure co-ordination of care, notes can be shared between professionals who treat the same patient. Access to the notes will be the responsibility of the coordinator of care of that specific patient. Confidential notes can be secured by a “my eyes only" section, giving only access to the professional who created that note. For example: If a patient is seen by the GP and referred to a psychiatric hospital due to the patient being highly suicidal, the psychiatrist will open the file, then through the platform can refer the patient to other members of the multi professional team, i.e. the psychologist, the in-house GP, the occupational therapist, the social worker, the physiotherapist, the dietician, the speech therapist and others. As he/she refers the patient, he/she can grant access to the notes to each of these other members of the MDT and can then follow the progress of the patient by reading the notes of the other professionals. Notes can be shared and the treatment plan can be jointly designed to suit that patient and to improve the outcomes. Care can be optimally coordinated. Messages can be sent between the professionals via SMS, WhatsApp or email or other secure platforms to organize MDT meetings or joint family sessions etc.

30. The aim of treatment is to facilitate a health outcome as close as possible to normal functioning, not merely the absence of symptoms.

SASOP Comments on the NHI Bill

31. In order to avoid unnecessary lengthiness of discussion, only selected points are commented upon. However, the sentiment expressed is applicable to all similar content in the NHI Bill.

Pre-Amble

32. The Pre-amble of the NHI Bill makes reference to the progressive requirements of Section 27(2) of the Constitution and also that the NHI model is aimed at achieving sustainable and affordable funding of healthcare services. It is important in terms of research by Docrat *et al*[35] that the costs of the required services form an integral part of NHI planning. If there is no indication of the costs of rendering healthcare services, whether for mental health care or any other condition, it is difficult to make a pronouncement on whether the model will be affordable and sustainable. Both these terms are functions of cost and therefore the absence of costing in the NHI Bill is of concern. Should costing prove problematic in terms of affordability, it could lead to less availability of services than is envisioned in the NHI Bill and could prove regressive in nature which would be contrary to Section 27(2) of the Constitution. Although SASOP does not proclaim to be experts in public financing, mentally ill patients are often the most vulnerable in society and any service shortages due to insufficient public budgeting for NHI will have the largest effect on this vulnerable community. Claims of sustainability are made, but they are not underpinned by a costing model published in conjunction with the NHI Bill. Research[35] has shown that mental health human resource availability, infrastructure and medication supply are a significant constraint in the progressive realization of the country’s mental health legislation. It is therefore imperative that this situation is alleviated by the increased availability of all such resources. The availability and origin of such increased resources is not sufficiently clarified in the Bill.

Access to Healthcare Services:

33. In the population groups who are eligible for services under NHI, it is concerning that asylum seekers and foreign nationals, who are amongst the most vulnerable and stigmatised members of South African society, will be left without any access to mental health care, outside of emergency services. Mentally unstable

[35] Docrat S, Mesada D, Cleary S Daviaud E, Lund C. Mental health system costs, resources and constraints in South Africa: a national survey. Health Policy and Planning, 2019, 1–14

immigrants and asylum seekers who require medication, admission or ongoing management, could pose a danger to themselves and others in the community and yet are being deprived of accessing such services through NHI, except in cases of emergency. It is not clear whether admissions to a mental facility as para-suicides or following harm to others would be possible in the NHI model for this group. Failure to manage such patients would lead to further attempts at self-harm or harm to others, the results of which would need to be managed by the NHI system. Many of these individuals are indigent people from other African states who come to South Africa due to the unstable political environment and failed economies of their home countries. Such individuals are often under severe socio-economic and psychological stress. They are highly vulnerable to mental illness. We believe that this clause may exacerbate and justify xenophobic behaviour in South Africa. In addition, it compromises the health workers' personal integrity, as it forces us to refuse treatment to patients against our will and conscience. Instead of further victimising this vulnerable and marginalised group of people and imposing an unethical demand on health workers, the costs of providing care to asylum seekers and illegal immigrants should be recorded and their countries of origin invoiced accordingly.

34. Regarding service coverage of NHI we are in support of the development of a comprehensive package of health services, with continuity of care across service levels and an emphasis on community and Primary Health Care (PHC). We are pleased to note the inclusion of mental health and substance abuse in the comprehensive package previously proposed in the NHI White Paper, but are simultaneously concerned of the absence of any indication of what the NHI service basket would look like, despite two years having passed since the White Paper. We are also concerned with how the service package is determined. We acknowledge that "everything for everyone" (as stated in the White Paper) cannot be covered, but we are acutely aware that neither mental illness nor substance use disorders receive adequate attention by most health departments in Low and Middle Income Countries.[36] In order to ensure sufficient cover of mental health services, we propose that the NHI Benefits Advisory Committee should include a Public Mental Health specialist. Further to this, absolute transparency and accountability from the NHI Fund is essential in the determination of which NHI service entitlements are considered "medically necessary." The grounds of such determination should be disseminated for inspection to all medical schools, professionals in the private sector and all professional societies. Such considerations must be consistent with the Constitution of South Africa and the health care rights of the individual.

35. We fully support the emphasis on PHC and the process of PHC re-engineering towards an integrated system of health care at the community level. We are heartened by the "Ideal Clinic" model and the inclusion of private health care services into the system. We do, however, have some concerns. Firstly, the description of the Ideal Clinic places emphasis on what the patient may receive. Whilst we agree with this, we hope that the rights of health care providers are included. It will not be possible to deliver on this model if service providers cannot be retained in the system due to excessive demands on their time and energy in order to meet the needs of patients according to the Batho Pele principles. There is still currently a concerning a lack of detail regarding the remuneration of public clinics and contracted private practitioners. There is mention of Capitation payments for private GPs, but the clinics themselves may be paid on a Global budget or similar capitations system. Both these re-imbursement models have inherent problems of underservicing and an increase clinical risk to the patient, it is therefore recommended that other alternatives of re-imbursement be sought in investigated. Models that incorporate a "pay-for-performance" payment model, improves

[36] Saraceno B, van Ommeren M, Batniji R, Cohen A, Gureje O, Mahoney J, et al. Barriers to Improvement of Mental Health Services in Low-Income and Middle-Income Countries. Lancet. 2007;370(9593):1164-74.

quality of care[37]. As Clinics are not juristic persons, the question has to be raised on how clinics will be changed into entities that are able to contract with the NHI Fund or with the Contracting Unit for Primary Healthcare. There would have to be changes to the clinic in order to be contractable to the CUP or NHI Fund. This would mean either becoming a Trading Entity under the Public Finance Management Act, or a Public Entity. No indication is given on how this process will be managed and what will happen to staff transfer from the Public sector into such an entity. More information on this process needs to be provided. No indication is given on how private providers or the suggested private multi-professionals psychiatric practices will be funded or contracted and how in- and outpatient care should be delivered. A concern is that psychiatric care is viewed primarily as hospital-based care, with very little recognition of the value/importance and need for outpatient/community psychiatric care.

36. The funding of health care must be managed by funders and managing health must be managed by healthcare providers independently. An independent organisation must keep both funder and service provider accountable to the services they must deliver whether it's *paying* for appropriate healthcare or *delivering* appropriate healthcare. The Bill proposes no independence between funder and healthcare providers with the funder totally in control of the system with no accountability. It creates a totally unfair biased system in favour of the funder to the detriment of the healthcare provider and user.

37. The Bill makes no provision to protect the rights and interest of providers of services, only users, creating an imbalance of rights. It has no mechanism to protect users and providers against abuse of their rights by the fund. The Bill proposes that the fund investigates complaints against itself, which is highly irregular. It is proposed that the previously proposed independent body, to which all role players are accountable to, investigate complaints against the fund, the providers and the users.

38. An additional concern we wish to raise is the training of sufficient numbers of mental healthcare staff to serve everyone in the system. Current training is insufficient to provide enough Human Resources and there is little details in the NHI Bill on whether training in the NHI environment will be expanded to include private facilities, or whether Public facilities will also be burdened with having to train students. The NHI payment model does not necessarily indicate that funding for training activities will be included in the Global Budgets allocated to Public hospitals involved with training. Academics involved in lecturing might spend half their day lecturing and the other half supervising, but are currently employed by the Province. Should such a person be employed by the facility itself, the facility might reconsider this employment relationship if the Academic in question renders limited clinical services in the facility, but still requires a full salary. Many training functions do not have direct patient care purposes and will not add to service delivery output from a facility. It is thus conceivable that there will not be any incentive for public facilities to be involved with training of healthcare students or registrars, if faced with constrained budgets. A funding model of such Academic/Training posts in the NHI environment needs to be considered urgently. SASOP is of the opinion that training should be expanded to private facilities under NHI and that incentives are provided to all facilities involved with training to ensure a sufficient supply of human resources to implement NHI. The proposed model entails training and continued professional development of all professionals in the private sector, from the nurses to the psychiatrist. The cost of such training should be borne in mind when funding the system is considered.

39. Certain details contained in the White Paper were not elaborated on in the NHI Bill and we are not certain whether previous objections by SASOP with regards to positioning of Mental Health care services were noted. The White Paper only mentions psychiatric services at the level of the Regional hospital. Specific sections of the White Paper implicitly excludes psychiatric services in District hospitals as it states that "…level 1 (district)

[37] Unutzer J, Chan YF, Hafer E, et al. Quality improvement with pay-for-performance incentives in integrated behavioral health care. American journal of public health and the nation's health. 2012;102:e41–45.

services will be provided by generalist medical (and dental) practitioners including surgical interventions under anaesthesia." This exclusion is not consistent with the Mental Health Care Act of 2002 (MHCA)[38] or the NMHPF, which endorse mental health care, treatment and rehabilitation at all service levels. Of note, community-based care is a particular requisite of both the MHCA and the NMHPF. With its emphasis on specialised psychiatric facilities, the White Paper advocates an outdated and costly model of psychiatric care, with no different model contained in the NHI Bill. This stands in opposition to the community-based care objectives of the MHCA and NMHPF. It is not at all consistent with WHO recommendations[39] or with international or local models of cost-effective psychiatric care.[40,41,42,43,44] The model of psychiatric care described in the NHI White Paper and which was not amended in the NHI Bill, is liable to increase hospitalisation costs without improving mental health coverage of the population. The discordance between national health plans and mental health legislation and policy does however explain why there has been no development of community-based psychiatric services in South Africa, even though deinstitutionalisation has already taken place. As stated in the NMHPF Section 2.5, page 16: "Deinstitutionalisation has progressed at a rapid rate in South Africa, without the necessary development of community-based services. This has led to a high number of homeless mentally ill, people living with mental illness in prisons and revolving door patterns of care."[45] Whilst we applaud the emphasis on primary mental health care in the NHI Policy, this is not a substitute for specialist community mental health teams (CMHTs).[46] In Nigeria, fifteen years of integrated primary mental health care failed to meet the goals of increasing mental health coverage and of reducing stigma and discrimination of the mentally ill. This failure is attributed to the absence of structured support and supervision of PHC by specialist mental health professionals, as this aspect of the Nigerian National Mental Health Programme and Action Plan was not implemented by health authorities.[41]

40. At a district hospital level, Psychiatry needs to be integrated into each discipline within the scope of practice of generalists in South Africa. This includes the provision of 72-hour observation for acute mental disturbance (as is already occurring in South Africa at District level) and the assessment and treatment of mental illness and substance use disorders in women presenting to obstetrics and gynaecology, children receiving child health care and people of all ages presenting for any medical cause for surgery or to family medicine.

41. The infrastructure of District Hospitals therefore needs to include facilities for 72-hour observation of severely behaviourally disturbed patients. Both District Hospitals and Community Health Centres / Ideal Clinics need to have built in room space for group therapy and workshop space for occupational therapy. Room space for group therapy / self-help groups must be such that confidentiality of the group is maintained. CMHTs must be established and adequately staffed to provide support and supervision to the District hospital generalists and to co-ordinate referrals of patients with severe mental illness for specialist admission or specialist community-based outpatient care.

Quality of services

[38] Government of South Africa. Mental Health Care Act No.17 of 2002. Pretoria: Government Gazette; 2004.
[39] WHO. Mental Health Action Plan 2013 - 2020. Geneva, Switzerland: World Health Organisation; 2013.
[40] Patel V, Chisholm D, Parikh R, Charlson FJ, Degenhardt L, Dua T, et al. Addressing the Burden of Mental, Neurological, and Substance Use Disorders: Key Messages from Disease Control Priorities, 3rd Edition. Lancet. 2015.
[41] Lund C, Flisher AJ. A Model for Community Mental Health Services in South Africa. Trop Med Int Health. 2009;14(9):1040-7.
[42] Lund C, Boyce G, Flisher AJ, Kafaar Z, Dawes A. Scaling up Child and Adolescent Mental Health Services in South Africa: Human Resource Requirements and Costs. J Child Psychol Psychiatry. 2009;50(9):1121-30.
[43] Lund C, Flisher AJ. Norms for Mental Health Services in South Africa. Soc Psychiatry Psychiatr Epidemiol. 2006;41(7):587-94.
[44] Thornicroft G, Tansella M. The Balanced Care Model for Global Mental Health. Psychol Med. 2013;43(4):849-63.
[45] DOH. National Mental Health Policy Framework and Strategic Plan 2013 - 2020. Pretoria: Government of South Africa; 2012.
[46] Saraceno B, van Ommeren M, Batniji R, Cohen A, Gureje O, Mahoney J, et al. Barriers to Improvement of Mental Health Services in Low-Income and Middle-Income Countries. Lancet. 2007;370(9593):1164-74.

42. We fully support and are enthusiastic about the work done by the Office of Health Standards Compliance (OHSC). It is noted that only 6 of 696 government facilities reported on in the 2016/2017 inspection results met with OHSC standards when inspected. With the NHI Fund being unable to contract with facilities of insufficient quality, it is vital that government facilities are brought up to levels of qualification. The structure of NHI also needs to be such that the facilities do not degrade over time to a point where they no longer qualify to contract with the NHI fund, due to funding challenges for maintenance, or a lack thereof. Within the previous draft Bill there was an indication that Provinces would be responsible for maintenance of facilities, this is no longer present in the current Bill. The question of maintenance responsibility needs to be addressed and clarified with urgency.

National Health Insurance Fund

43. Whilst we support the principles of UHC, we have several concerns regarding specific features of NHI. In particular, we are concerned that pooling all health financing sources into a single fund carries the risk of damaging the entire health system irreparably, should this fund be mismanaged. Our concern is based on the fact that the National Department of Health (NDoH) achieved unqualified audit reports for only three years over a nine-year period.[47] If it is unable to deliver qualified audit reports in the current system, will it have the capacity to administer the enormous pool of funds under a single financing system? The Workmen's Compensation Fund, as a publicly administered funder of Healthcare services, has also achieved a qualified audit in the previous financial year, despite having the same governance model as proposed for the NHI and being considerably smaller in fiscal size.

44. For the same reason, the "single-payer" model, with no competing entity, is a great concern. Although simplifying the financial management of the health system should reduce opportunities for corruption through the reduction of multiple agents and public-private relationships, the NDoH has also been accused of corruption.[47] Should this single-payer fail in any way, then there is no recourse to an alternative funding source for anyone in South Africa.

45. In order to generate public confidence in NHI, the financial management of the current public health system and entities such as the Compensation Fund should become reflective of that envisaged by NHI, particularly in terms of transparency and accountability.

Conclusion

46. SASOP is encouraged that Government is taking initiative to achieve universal healthcare in South Africa. We have provided a possible service delivery model which can be used in the NHI system and also in any interim arrangements towards NHI. We want to caution government against implementing large scale systemic changes before more clarity is achieved on how NHI will practically be implemented, funded and administered.

Kind Regards,

Prof Bonga Chiliza

[47] Rispel LC, de Jager P, Fonn S. Exploring Corruption in the South African Health Sector. Health Policy Plan. 2016;31(2):239-49.

SASOP President (2018-2020)