SOUTH AFRICAN HUMAN RIGHTS COMMISSION

SAHRC SUBMISSION ON THE NATIONAL HEALTH INSURANCE BILL [B 11-2019]

Submitted to the Portfolio Committee on Health

November 2019

---

1 INTRODUCTION

The South African Human Rights Commission (SAHRC/Commission) supports the development of a single healthcare system for South Africa using a National Health Insurance (NHI) for the purchase of healthcare services. If well administered the NHI has the potential to contribute to addressing inequality in the healthcare sector and thereby assist in the reduction of poverty in South Africa.

The success of the NHI will, however, depend on, among others good governance. The NHI must be adequately protected against corruption, mismanagement and various forms of abuse that have often characterised and bedevilled well intentioned programmes of successive governments that are intended to promote equality and good health care in South Africa. At the centre of good governance of the NHI should be proper checks and balances without which the NHI will unfortunately be doomed to fail.

The Commission has some concerns to the existing National Health Insurance Bill (NHI Bill) as circulated for comment. The concerns of the SAHRC are set out below.

2 THE MANDATE OF THE SAHRC

The SAHRC is a constitutionally created independent institution supporting democracy. It is mandated by Section 184 (1) of the Constitution of the Republic of South Africa (Constitution)[1] to:

> (a) promote, respect for human rights and a culture of human rights;
> (b) promote the protection, development and attainment of human rights; and
> (c) monitor and assess the observance of human rights in the Republic.

The powers and functions of the Commission are further elaborated upon in Section 13(1)(a)(i) of the South African Human Rights Commission Act 40 of 2013 that requires the Commission to:

> (i) Make recommendations to organs of State at all levels of government where it considers such action advisable for the adoption of progressive measures for the promotion of human rights within the framework of the Constitution and the law, as well as appropriate measures for the further observance of human rights;

Further, Section 13(1)(b)(v) states that the Commission must:

> (v) Must review government policies relating to human rights and may make recommendations.

In addition to the above constitutional and legislative provisions, the *Principles Relating to the Status of National Institutions* (the Paris Principles) adopted by United Nations General Assembly Resolution 48/134 in 1993 require national human rights institutions (NHRIs) to:

> (a) To submit to the Government, Parliament and any other competent body, on an advisory basis either at the request of the authorities concerned or through the exercise of its power to hear a matter without higher referral, opinions, recommendations, proposals and reports on any matters concerning the promotion and protection of human rights; the

[1] Act 108 of 1996. Hereinafter the 'Constitution'.

national institution may decide to publicise them; these opinions, recommendations, proposals and reports, as well as any prerogative of the national institution, shall relate to the following areas:

(i) Any legislative or administrative provisions, as well as provisions relating to judicial organisations, intended to preserve and extend the protection of human rights; in that connection, the national institution shall examine the legislation and administrative provisions in force, as well as bills and proposals, and shall make such recommendations as it deems appropriate in order to ensure that these provisions conform to the fundamental principles of human rights; it shall, if necessary, recommend the adoption of new legislation, the amendment of legislation in force and the adoption or amendment of administrative measures;

(b) To promote and ensure the harmonisation of national legislation regulations and practices with the international human rights instruments to which the State is a party and their effective implementation.[2]

It is therefore in line with the above mandate of the Commission that it is making input into the NHI Bill.

3 COMMENTS ON THE NHI BILL

3.1 Definitions

Basic health care services

The Act has not defined what "basic health care services" is. This definition is important especially in light of the fact that reference is made to provision of "basic health care services". The definition of "basic health care services" must be in line with the Constitution as well as accepted international standards.

[2] *Principles Relating to the Status of National Institutions*, available at, http://www.ohchr.org/EN/ProfessionalInterest/Pages/StatusOfNationalInstitutions.aspx

3.2 Population Coverage

The NHI Bill further limits access to healthcare by asylum seekers in South Africa. It is common cause that it takes a long time to finalise immigration matters of persons who are seeking asylum. Persons seeking asylum are therefore left in an indeterminate state especially as far as registration for services is concerned. The Commission has on numerous occasions raised concerns about the slow processing and finalising asylum seekers' applications, in some cases waiting periods taking several years. What will happen to such persons in the interim ie while their applications are being considered?

The Commission notes that Section 4 of the NHI unfairly discriminates against asylum seekers and undocumented migrants and thereby unlawfully restricts their right to access health care in South Africa. Under Section 4 of the Bill, asylum seekers and undocumented migrants are only entitled to —

> "emergency medical services, treatment and screening for notifiable conditions of public health concern."

Section 27 of the South African Constitution[3] guarantees everyone the right to primary health care. It states that "*Everyone has the right to have access to health care services, including reproductive health care*." Migrants' socio-economic rights have been developed and given meaning by the courts. In *Khosa and Others v Minister of Social Development and Others; and in the matter of Mahlaule and Another v Minister of Social Development and Others*[4], the Constitutional Court held that equality in respect of socio-economic rights is implicit in the use of the word 'everyone' in Section 27(1) of the Constitution in respect of those entitled to the rights set out therein.

In *Lawyers for Human Rights and Another v Minister of Home Affairs*[5] the Constitutional Court held that when the South African Constitution limits rights to citizens, it clearly expresses that limitation. Therefore, because the Constitution did not expressly reserve the rights mentioned above for citizens, all those living within South Africa's borders are entitled to them.

To the extent that the Bill seeks to limit the right of foreign nationals to access health care services, the Bill will need to pass the proportionality test set out in section 36 of the Constitution, and be

[3]The Constitution of the Republic of South Africa, 1996.
[4] *Khosa and Others v Minister of Social Development and Others* 2004 6 BCLR 569 (CC) para 56.
[5] *Lawyers for Human Rights and Another v Minister of Home Affairs and Another* 2003 (8) BCLR 891 (CC).

upheld as reasonable and justifiable in an open and democratic society based on human dignity, equality and freedom. In particular, the Commission recommends that less restrictive means be employed to limit this right for foreign nationals, instead of automatically excluding this vulnerable group from accessing health care services beyond emergency treatment.

Moreover, Section 27(2) of the Constitution, imposes an positive duty on the State to take reasonable legislative and other measures, within its available resources, to achieve the progressive realisation of each of these rights. Protecting these rights, places a duty on the State, to develop and implement a comprehensive legal framework which does not interfere with existing right to access to health care. The NHI is thus not in line with this constitutional requirement and is retrogressive in matters pertaining to asylum seekers and undocumented migrants. The Commission notes that the NHI removes the rights contained in Section 4(3)(a) of the National Health Act 61 of 2003, which states that:

> "Subject to any condition prescribed by the Minister, the State and clinics and community health centres, funded by the State must provide - (a) pregnant and lactating women and children below the age of six years, which are not members or beneficiaries of medical aid schemes, with free health services; "

The Commission further is concerned that the NHI no longer allows pregnant and lactating women, irrespective of their legal status, the right to access free primary health care services. Similarly, the best interests of the child are of paramount importance in any matter concerning the child.[6] Consequently, the legal status of children cannot deprive them of constitutionally enshrined rights.

3.3 Powers and functions of Chairperson, Deputy Chairperson and Members of the Board

The NHI Bill needs to clearly state what the powers and functions of the Chairperson, Deputy Chairperson are as well as powers and functions of individual members. Such a state of affairs will help to clarify potential conflicts and ensure an efficient Board and assist in the decision-making process.

[6] Section 28 of the Constitution.

The Commission notes that the Bill does not specify a minimum term of appointment for the appointment of the Board. The Bill merely states that:

> "…..a Board member is appointed for a term not exceeding five years, which is renewable only once…[1]"

The absence of a definitive fixed term of appointment is a concern as an appropriate minimum term of appointment is essential in promoting the independence of the Board and also ensures continuity. The Commission recommends that each member should serve a minimum term of three (3) years to achieve the above-highlighted objectives.

Section 44 establishes the Appeal Board that should be chaired by the chairperson of the Board. Whereas Section 13(5)(b) provides for a wide array of skilled persons to serve on the Board and Section14(1) requires the Minister to appoint a board member from among the members of the Board, Section 44 seems to limit who the chair of the board must be (requires that the person must have knowledge of the law) the implications is that only board members who are legally qualified or experienced should be the Chairperson of the Board. The reality may be that among board members there may be other persons who are technically better qualified to chair a board dealing largely with medical issues. Section 44 therefore while not dealing with appointment of Board members seems to introduce who the Chairperson of the Board should be.

3.4 Conditions of service of board members

The remuneration and conditions of service of Board members should be clearly stipulated. If clearly stated this may help to protect the Board from undue external interference and thereby help to guarantee the Board's independence.

The Commission notes that in terms of Section 18 of the NHI Bill;

> "…the Fund may remunerate a Board member and compensate him or her for expenses as determined by the Minister in consultation with the Minister of Finance and in line with the provisions of the Public Management Act"

[1] Section 13(5).

The Commission recommends that the remuneration of the Board be determined by the Independent Commission for the Remuneration of Public Office-Bearers in line with the Remuneration of Public Office Bearers Act 20 of 1998 so as to guarantee its independence.

3.5 Stakeholder Advisory Committee

Section 27 provides for the establishment of a stakeholder advisory committee. Considering the work that the Commission has done over the years in the area of health rights, it is important that the Commission is included in this advisory committee. Other relevant Chapter 9 institutions, for example, the Commission on Gender Equality should also be considered for addition on the advisory committee.

3.6 Appeal Tribunal

The Appeal Tribunal to be established in terms of Section 44 will be chaired by the Chairperson of the Board. Section 1 defines the word “Board” as the “Board of the Fund established in terms of Section 12”.

The Appeal Tribunal should ideally be completely independent of the Board to avoid complications that could arise in terms of matters going before the Appeal Tribunal that may have already been before the Board. The credibility of the Board will be affected if the Appeal Tribunal has a connection to other bodies within the Fund.

3.7 Concentration of power in the Minister

The Commission notes that in terms Section 12 of the NHI Bill, the Board is accountable to the Minister of Health. In terms of Section 13, the Board is appointed by the Minister, who is also empowered to remove any of its member(s) or dissolve the entire Board. The Commission is concerned with both the appointment process of the Board and its reporting lines. The proposed governance structure places concentrated power on the Minister and does not adequately ensure the independence of the Board, which is essential given its extensive powers, including strategic purchasing and the buying and selling of property.

Furthermore, it locates excessive indirect authority with the Minister. The Commission recommends that the Bill should include further mechanisms for accountability and oversight which are legislated and that considering the importance of NHI, the process of appointing and removal of members of the Board should be akin to the process of appointing and removal of members of Chapter 9 institutions whereby the National Assembly is involved in the process. The Board should report to the Minister but the National Assembly should play an oversight role thus the annual report should be tabled before Parliament.

To avoid a conflict of interest, the ministerial representative envisaged may neither be appointed as the Chairperson nor Deputy Chairperson of the Board. It is also recommended that committees be appointed by the Minister in consultation with Parliament.

Finally, Chapter 4, Section 13(5) indicates the criteria required for a Board member to be appointed. It should specify that the Board members should not have criminal records and must be persons of high intergrity.

3.8 Governance

The NHI in its current form is complex and offers myriad opportunities for corruption and looting, particularly in areas where contracts are entered into. Strong governance structures are required to monitor unlawful activities. Strong governance structures are required to ensure the accountability of purchases and contracted parties both to users and the State and to ensure accountability of the State to users and Parliament.

3.9 Registration of users

The Commission notes that Section 5 (5) of the Bill requires a person:

> "When applying for registration as a user, the person concerned must provide his or her biometrics and such other 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."

However, not everyone in South Africa has a birth certificate and or an Identity Document (ID). There are many South Africans who do not possess any form of positive identifcation. This requirement may limit their access to health care as they will not be permitted to register as users. Furthermore, this section also fails to take into account the plight of stateless persons living in South Africa who do not possess any form of identification. The Commission recommends that the State considers other forms to identify individuals positively. Alternative means of identification and proof of residence, such as affidavits, will further constitute “less restrictive means” in limiting the right of access to health care services, while wsimultaneously constituting “reasonable measures” in progressively realising the right in terms of section 27(2) of the Constitution.

3.10 Relationship between the Minister and Chief Executive Officer

The Commission notes, with concern, that Section 21 of the NHI establishes a relationship between the chief exceutive officer (CEO) and the Minister even though the CEO is accountable to the Board. The Commission recommends that there should be a separation between political and operational spheres as this may weaken the role of the Board. The Commission recommends that the meeting where the CEO (who is an ex officio member of the board as per Section 13(6)) should be present should also include the Chairperson of the Board, Deputy Chairperson and an additional member of the Board elected by other members to represent them at the meeting.

3.11 Operation of the Fund

The Commission notes that the NHI provides for a single purchaser of health care services based on population needs. The Commission welcomes this approach as it allows the Fund to ensure that it purchases services at lower prices and also because it allows the Fund to control health care spending and diverts health care resources to the needs of the population. This, in turn, allows for greater efficiency in health care expenditure and limits fruitless and wasteful expenditure.

However, there remains great confusion about particular aspects of the NHI, including that of the role of Contracting Units for Primary Healthcare. Under Section 37 it is noted that contacting units are directly contracted by the NHI for the provision of primary healthcare services. However, elsewhere the NHI indicates that contracting units will oversee provision and commission or purchase services on behalf of the NHI Fund. Clarity is required. Furthermore, what is the role of the contracting unit if the NHI Fund is contracting service providers directly?

Section 35(2) of the NHI states that accredited and contracted central, regional, specialist and district hospitals will be reimbursed based on a global budget or diagnosis-related groups (DRG). While the Commission understands the need to control over expenditure given the ever increasing medical costs, it is, however, concerned about the impact of using a DRG as a mechanism for reimbursing health care providers, particularly for secondary and teraity healthcare facilties.

A DRG is not able to take into account the particular situation of rural areas. DRG focuses on in-patient numbers and case mix; however, rural facilities devote more resources to outpatient consultations.[7] Given the barriers to accessing health care in rural areas, hospitals are forced to provide health care services outside the hospital through various outreach programs, and these outreach programs have budgetary implications for the hospitals. The Commission recommends that these outpatient expenses be taken into account over and above the DRG funding model.

The Commission also notes that the DRG model fails to take into account obstacles to care experienced by rural health care facilities, especially concerning physical barriers to access, such as patient transport. While the White Paper provided for the NHI to cover the transport of patients to get to health care, the NHI Bill only provides for ambulance transfer from one level of care to the next, only once a patient has accessed the system. There is a need for the State to consider covering transport to primary care sites, where there is demonstrable need. This is particularly so for rural communities who not only face barriers to access health care services due to vast distances between health care facilities and residential areas but also due to socio-economic hurdles which include the availability of public transport and ability to finance transportation to health care facilities. The State should continue to explore the possibility of providing remote access to health care services, initially by ensuring that all health care facilities enjoy reliable internet connectivity. ICT infratsructure should be progressively rolled out to rural areas.

Section 36 speaks to District Health Manangement Offices. It is unclear who these offices report to and if it is to the National Department of Health, this would seem like a huge administrative, oversight task for the national department. Furthermore, there is lack of clarity on the difference between District Health Management Offices and contacting units.

[7] http://rhap.org.za/green-paper-final-policy-change-rural-considered-relation-national-health-insurance-process-south-africa/ accessed on 23 September 2019

The Commission notes that Section 37(2) of the NHI provides for the establishment of ward-based outreach teams (WBOTs), but there is no mention of their accreditation nor does the NHI address their funding. Given the demonstrable benefits that Community Health Workers in WBOTs and given how they can deliver health care at low cost, they must become a prominent feature of the NHI. The Commission recommends that the issue of the role, functions, accreditation and funding model for Community Health Workers in WBOTs within the NHI, needs to be adequately addressed within an integrated HRH plan.

The NHI is unclear on which health establishments and professionals will be contracted by the Fund. Does the contractual process include private healthcare establishments and how does the NHI Fund plan to reimburse such providers to ensure that quality healthcare is provided. It is also unclear what reibursement method or form the NHI will employ.

Finally, it is unclear what a benefits package for users will consist of and transparency and access to information on this is essential to understand the extent of cover users can expect.

3.12 Information Platform of Fund

The Commission notes that Section 40(4) of the NHI requires health care providers to keep patient information such as information relating to patient health. The Commission is of the view that the NHI does not adequately address current challenges with patient record keeping and is not clear on how patient records and biometric information will be secured to ensure confidentiality. The Commission through it's monitoring work of health care facilities has noted that the current health care system has weak patient record system which, is exacerbated by the fact that most health facilities use a manual data capture system and that health care facilities lack adequate administrative staff. Before the NHI can be implemented, considerable reform and capacitation is required. The Department of Health would have to consider upgrading the current IT system as the implementation of the NHI requires the electronic registration of new users. The Department of Health will also need to reform the administrative infrastructure, train and recruit skilled personnel to meet staffing demands.

4 CONCLUSION

At present, the South African healthcare system is not equipped to provide healthcare services for all South Africans. Much upscaling of resources and capacity will be required prior to the implementation of the NHI. Furthermore, governance will have to be improved drastically. It is essential to note that the funding of the NHI must not occur at the expense of other rights and services provided by the State and must not result in retrogressive measures in the provision of rights. Noting the above, an accessible, effective, efficient, approprite and adaptabile healthcare system that provides quality healthcare services to its users has the potential to significantly reduce poverty and inequality in the country and reduce the wastage of invaluable resources and capacity, which is desperately needed in the public sector.