28th November 2019

SUBMISSION ON THE NHI BILL NO 11 OF 2019.

1. Introduction to Counselling Psychology South Africa (CPSA).

We wish to thank the Honorable members of the Parliamentary Health Committee for the opportunity to comment on this National Health Insurance (NHI) Bill as introduced into Parliament in August 2019, and hope that, in time, it will have a significant positive effect on the mental health of all South Africans. We are more than willing to engage further with the Committee to discuss and refine the ideas presented in this submission in order to develop the provision of mental health services in the NHI.

We first wish to introduce ourselves to the Health Portfolio Committee.

Psychology South Africa (CPSA) is a voluntary association of members, being counselling psychologists registered with the Health Professions Council of South Africa (HPCSA), and governed by a Constitution and various sets of rules adopted in terms of that Constitution. The Association's management and oversight are carried out by an elected Executive Committee (ExCo). The association has a number of goals that include:

1.1 To make a meaningful contribution to mental health care needs in South Africa, whilst promoting and facilitating the maintenance and enforcement of ethical and professional standards;

1.2 To assist in the fair and relevant development of counselling psychology, including enhancing, guiding and protecting the rights and interests of counselling psychologists and the profession on ethical, professional and clinical matters, and thereby promote fair and equitable access to mental healthcare services; and

1.3 To advise, assist and contribute to the development and implementation of equitable policies and standards that will promote access to mental healthcare services.

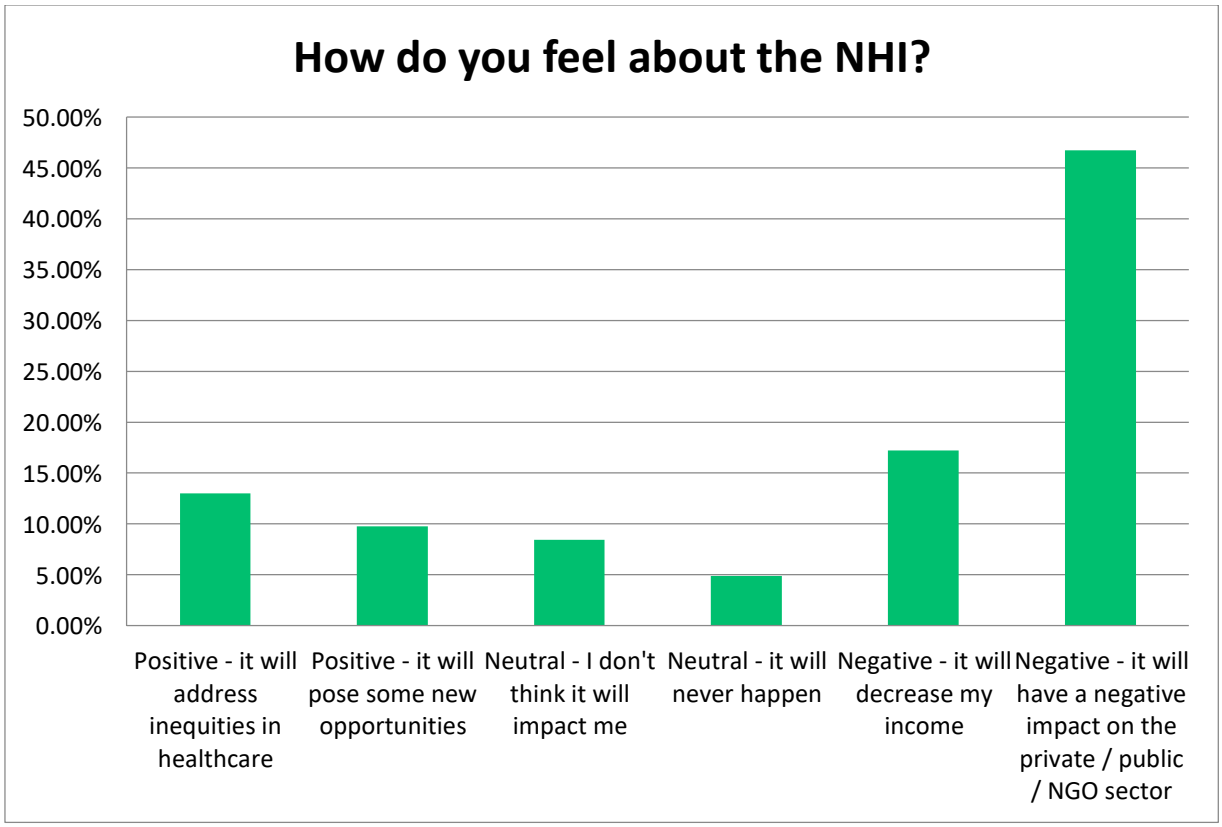
The field of Counselling Psychology is a specialist category within professional psychology that promotes the personal and social functioning, career functioning, mental health and well-being of individuals, couples, families, groups, organisations and communities. Counselling psychologists prevent, diagnose and treat **psychological and mental health disorders** that range from mild to moderate severity. Counselling psychologists deliver a range of high-intensity psychological interventions that take into account the therapeutic potential of positive relationships, and people's strengths and resources.

2. Equitable system of access to healthcare for all.

In a survey carried out amongst our members and members of EPASSA (the Educational Psychology Association of South Africa) in October 2019, it was found that 61.24% of our respondents were working in private practice (e.g. universities, schools, research, own private practices) and that 46.91% had a negative opinion on the implementation of the NHI because it will have a negative impact on their practices and livelihood. CPSA supports the ideals of what the Bill seeks to achieve and believe that the vision of quality Universal Health Coverage for all in South Africa is possible if there is a genuine commitment by all to this ideal. Section 27(1)(a) of the Constitution of South Africa, 1996 provides for access to healthcare for all.

We support the transformational initiatives of this Bill, which has at its aim the increase of access to healthcare, but our members feel overwhelmingly neutral to negative about the NHI. Most of the reforms required by which transformation is to be effected, however, reside outside of the NHI Bill, and require significant resources and restructuring of the health sector before it can be implemented, as our survey shows.

As the NHI Bill itself in its explanatory memorandum states, it aims to split the purchaser (i.e. the NHI Fund) and the provider functions of health care. ***However***, the NHI Bill ventures into the provision-side of health care, and in many instances are hoping for amendments in the National Health Act and to healthcare professions legislation in terms of processes that had not been started yet. Furthermore, the HMI recommendations on, for example, price negotiation, widely supported by all stakeholders, are at least some five years from implementation.



For too long already, access to adequate mental health care services have been constrained by under-resourced public health services, the high costs of private health services and limited practitioners in the field of mental health care. In the Preamble of the Constitution of the World Health Organisation (WHO)[1] it is stated that *"Health is not just the absence of disease or infirmity, but a state of complete, physical, mental and social wellbeing."* In an article in the International Journal of Mental Health Systems[2], it was stated that there is *"…an implicit neglect for the integration of mental health services into general health service development…".*

It is our view that the provision of mental health care services at multiple levels, including primary health care, district, secondary and tertiary levels is essential. The Mental Health Care act, 2002, in its preamble states that *"...health is a state of physical, mental and social well-being and that mental health services should be provided as part of primary, secondary and tertiary health services."*

The World Health Organisation's (WHO) Mental Care Gap Action Programmes (mhGAP) also provides for mental health care services that are integrated into PHC programmes[3]:

"The key advantages for delivering mental health care are that it is accessible, affordable and acceptable to people with mental health problems and their families…" and *"…mental health integration in primary care promotes comprehensive, coordinated, and person-centred care for the many people with comorbid physical and mental health problems."*

Furthermore, the provision of mental health care services could also be found in the following documents:

(a) The National Mental Health Policy (2013-2020)

This Policy acknowledges the importance of promoting psychological well-being and it also sets targets for the prioritisation of psychological services.

(b) The National Mental Health Policy Framework and Strategic Plan (2013-2020)

This Policy Framework and Strategic Plan states that mental health care services should have priority along with general health services.

(c) South African Human Rights Commission – Report of the National Investigative Hearing into the Status of Mental Health Care in South Africa[4]

This Report comments on the need for attention to the mental health and well-being of children and adolescents and also refers to the development of appropriate mental health services for people with psychological and intellectual disabilities. It also states that there is a considerable under-investment in mental health by the South African government.

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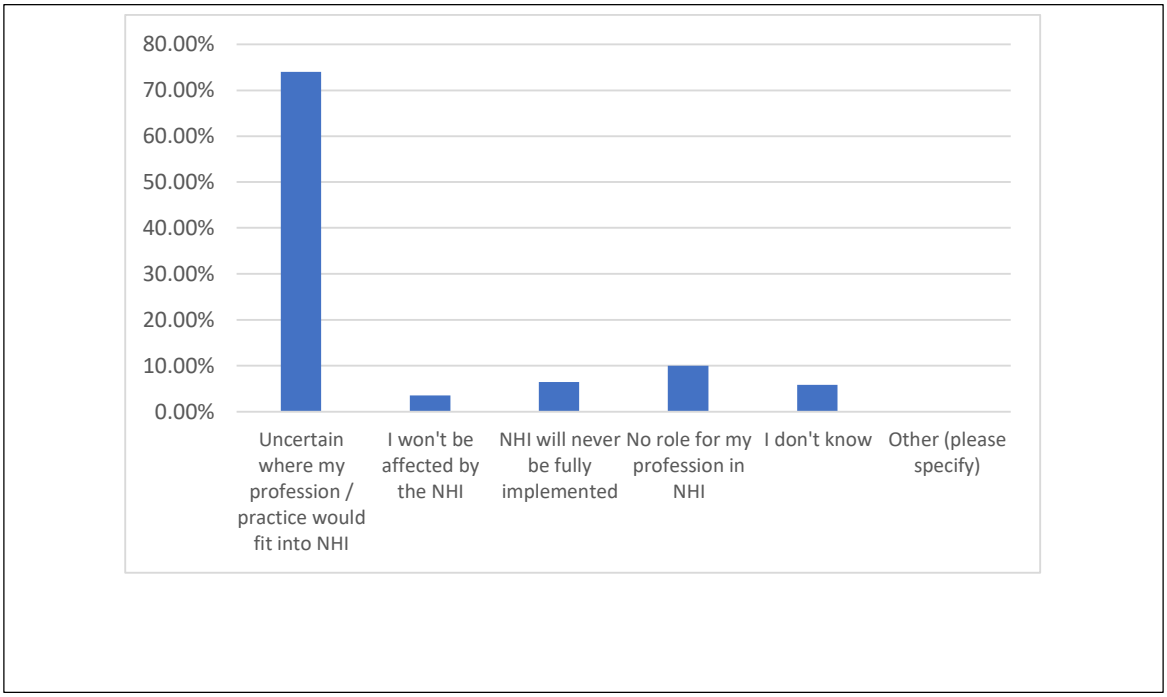
[1] who.int/governance/eb/who_constitution_en.pdf (Visited 15 November 2019).

[2] Dorat, S, Lund C & Chisholm D: Sustainable financing options for mental health care in South Africa: Findings for a situation analysis and key informant interviews: 13, 4 (2019) doi:10.1186/S13033-019-0260-4). 21 January 2019. (Visited 15 November 2019).

[3] WHO: Mental Health in Primary Care: Illusion or Inclusion?. 2018.(who.int/docs/default-source/primary-health-care-conference/mental-health.pdf?sfvrsn=8c4621d2_2 .(Visited 12 November 2019)

[4] Sahrc.org.za/index.php/sahrc-publications/hearing-reports. March 2019. (Visited 12 November 2019).

The focus of the profession of counselling psychology is on facilitating personal and interpersonal functioning, promotion of mental health and alleviation of mental and behavioural disorders across the life span of a patient / client and we are committed to providing every resource possible in the achievement of this. We do recognise the inequities in access to healthcare and strongly feel that this is undesirable and unsustainable and we are actively seeking practical solutions that can be implemented. The Survey we conducted on aspects of the NHI, and which is detailed below, shows a level of uncertainty as to whether the NHI Bill, as it stands, will be positive for the profession of psychology, with just under 75% being uncertain as to where their practices would fit into the NHI:



The inter-relationship and intersection between physical and mental health have been scientifically proven over and over. However, we are concerned that Psychologists are not included among the health care professionals included in Primary Health Care (PHC) coverage in the Bill and also that there is no specific reference to Psychology or Psychologists. Furthermore, there is no recognition whatsoever for psychologists that work in secondary- and tertiary care. The provision of Universal Health Care (as envisaged in the Bill) cannot be achieved in the absence of comprehensive mental health care services into the health care system in South Africa.

The treatment model implicit in the NHI is the same as currently practised in the public healthcare system. It relies on a strictly biomedical model with first point of access being nursing staff or General Practitioners. They may not necessarily be the best qualified or trained in this regard. There are no necessary or sufficient reasons why this should be so. Patients with any mental health challenge or disorder should be entitled to approach a mental healthcare practitioner, such as a psychologist, in the first instance as is currently the case in the private healthcare sector in South Africa, thereby reducing or eliminating barriers to accessing mental health care. Mental health *must* enjoy the same priority as physical health. The consequences of a failure to just that, have been tragically obvious in recent months, such as the Life Esidimeni case.

Mental health care goes beyond psychiatry and mental health facilities. Psychologists also play an important role in health care behaviour, and therefore are relevant in terms of persons adjusting to chronic or life-threatening illness, dealing with issues relating to disclosure of HIV status, adjusting to work-absences or changes in life that may be brought about by conditions such as cancer, or adjusting to being a diabetic, or a person disabled due to an accident at home.

As a membership organisation, we have, together with the Educational Psychologists, developed a survey to which our members have responded. The results of the survey will be used in this submission to support our members' views on NHI matters.

3. Our comments on the definitions in the Bill.

3.1. ***''Complementary cover''*** is defined in clause 1 as a *"third party payment for personal health care service benefits not reimbursed by the Fund, including any top up cover offered by medical schemes registered in terms of the Medical Schemes Act or any other voluntary private health insurance fund"* .This definition then provides that if a Private Healthcare Provider does not contract with the NHI Fund, the services rendered by him/her will not be reimbursed by the Fund and that such services would qualify for reimbursement as *"complementary cover".* This is then not in line with the provisions of clause 33 which states that *"Once the National Health Insurance has been fully implemented…medical schemes may only offer complementary cover to services not reimbursable by the fund"* (Emphasis provided).

Practically this means that if, for example, depression or bipolar mood disorder, or attention deficit hyperactivity disorder, is included as conditions for which benefits are provided, no medical scheme would be able to cover it. This will deprive a large number of patients from care already received. It should also be borne in mind that mental health treatments are long-term, and that a significant emphasis is placed on the trust relationship between service providers and patients / clients.

3.2. ***''Comprehensive health care services''*** is defined as *"health care services that are managed so as to ensure a continuum of health promotion, disease prevention, diagnosis, treatment and management, rehabilitation and palliative care services across the different levels and sites of care within the health system in accordance with the needs of users."* The Bill gives the promise of *"comprehensive care"* and also indicates that the NHI Fund will contract care at various levels. With regard to the progressive realisation of healthcare, as provided for in section 27(2) of the Constitution, section 57(4)(g)(ii) of the Bill only states that "*purchasing hospital services and other clinical support services, which must be "an expansion of the health services purchased*". The Bill shows limited integration of mental health services and if it is not going to be recognised as an integral part of the health care system there is going to be no progressive realisation to this effect for mental health patients.

Public hearings being held by the Portfolio Committee in various provinces since October have shown that many members of the public, supporting the NHI, are hoping that current problems with access to, and quality of care, will be solved by the NHI[5] There is, therefore, a hope that a more "comprehensive" package of care will be offered from the start, whilst this may not be possible, given budgetary constraints.

[5] See for example the reporting by Health-E News on the NHI provincial hearings, at https://health-e.org.za.

3.3. ***"Primary health care"*** *means addressing the main health problems in the community through providing promotive, preventive, curative and rehabilitative services and …in the public health sector, is the clinic, and in the private health sector, is the general practitioner, primary care nursing professional, primary care dental professional and primary allied health professional, through multi-disciplinary practices."* Allied Health Profession services include *inter alia* Aromatherapy, Chinese Medicine and Acupuncture, Chiropractic, Homeopathy. The question here is whether it is actually meant by the Bill that this refers to Occupational Therapists, Psychologists, etc. (all practitioners registered with the Health Professions Council of South Africa (HPCSA) and not the Allied Health Professions Council (AHPCSA)).

We would wish to point out that we do not consider psychologists to be allied, para - or complementary health professionals. Psychologists are required to obtain Masters degrees in order to register as such, which is the same level of academic qualification required of medical practitioners and dentists. Their level of functioning is described in section 37 of the Health Professions Act (Act 56 of 1974). Unlike other health professions regulated by Regulations to the Health Professions Act, psychologists have the statutory authority to *diagnose and treat* mental and behavioural disorders, admit and discharge patients to and from hospitals, and issue sick certificates as defined in section 23 (2) of the Basic Conditions of Employment Act, 1997 and thus enjoy the same legal status as doctors or any other person who is certified to diagnose and treat patients and who is registered with a professional council established by an Act of Parliament.

We would thus recommend the amendment of this definition by the insertion of the word "*psychologist*" immediately after the term "*general practitioner*".

We also wish to express concerns here to the reference to "*multi-disciplinary practice*". As stated further below in this submission, the majority of our members that were canvassed in the drafting of this submission expressed concerns as to how their current private practices will be accommodated in the NHI system. Whilst the multi-disciplinary nature of medical practices including nursing staff, General Practitioners, pharmacists, physiotherapists, occupational therapists, etc. is clearly understood, it must be questioned why this will be true of psychologists. Most psychologists only collaborate with medical practitioners regarding the treatment of their patients in a minority of cases, as psychotherapy is regarded as a first-line intervention for many mental disorders, such as depression, anxiety and trauma.

Psychologists are registered for Independent practice, and are therefore not required to work under supervision or by referral from General Practitioners We need to question whether this will result in the demise of private practice for psychologists, paid employment in the "corporatisation" of mental health care, a State take-over of mental health services or a negative impact on the clinical autonomy of the psychologist to make treatment decisions governed by ethical rules rather than multidisciplinary or financial drivers.

4. Organisation and Operation of the NHI Fund.

The purpose of the Act, as stated in Clause 2, is to "establish" and "maintain" the NHI Fund. This Act should not be about the manner in which the Fund will be funded (that would be the role of a Money Bill under the Constitution of South Africa), nor should it set out how the entities with whom it will contract, are to be organised. That is the function of the National Department of Health (NDOH) under legislation such as the National Health Act, and statutory professional councils.

It is important that, in order to meaningfully comment on this important re-organisation of the health sector in South Africa, three sets of laws to be reformed, must be published. This should have been published before the NHI Bill

was introduced into Parliament, as its success depends on it. Our ability to meaningfully anticipate and understand the reforms and its impact on us, and our patients / clients, are severely constrained by references to potential amendments, and a new Money Bill dealing with finances, without even the broadest of outlines provided:

- Changes to health care professional legislation that would, for example, allow receipt of "all-inclusive" fees and other amendments envisaged by the Health Market Inquiry Report, such as fee negotiation systems;
- Changes to the organisation of the public health sector, which affect those of us working in the public sector and also in the academic sector significantly. These changes would require amendments to the National Health Act, far beyond what is published in the schedule to the Bill, as well as changing our employer from being a province and/or a university, to being the National Department of Health, In spite of clause 3(4) statin that the NHI Bill does not in fact change the funding or functions of organs of state, it does exactly that – it changes public hospitals on where they get funding from, who they are accountable to, etc.; and
- The funding of the NHI, through a release of the financing model that will, over time, lead to the envisaged comprehensive package, and the release of the Money Bill that will deal with the levying of taxes and the appropriation of funds to the NHI.

5. Laws excluded from the NHI Bill

Laws such as the **Protection of Personal Information Act**, 2013 (POPI Act) and the **Consumer Protection Act**, 2008 are "constitutional laws" and derive their authority from the Constitution. This means that they cannot be overridden by the Bill. However, they are excluded from the Bill in clause 3(3) insofar as it may contradicts with the provisions of the Bill. For example, clause 5(5) refers to a registration system that will include biometrics, and clause 6(m) refers to disclosure "in the interest of users", whereas the POPI Act states that the processing of personal information must not "infringe the privacy of the data subject". The POPI Act also has mechanism in its section 4(2), which the NHI Fund would have to use should it want some or all of the POPI Act provisions to not find application.

Of particular concern to psychologists, who often deal with extremely sensitive personal information, is the provisions of clause 39(5), which makes payment by the NHI Fund subject to the disclosure of certain types of personal- and health information to the Fund mandatory. Unlike clauses 11 and 34, where information matters are prefaced by "subject to the" POPI Act, and other laws, this is not done in clause 39(5).

It should also be questioned why a "*user's*" statutory rights to Constitutional protection should be waived or diluted in terms of services, goods or treatment received from the NHI. The levels of service provided in the current public healthcare system frequently draw the Minister of Health into court actions for compensation for malpractice or mistreatment of patients. This should be intolerable in the NHI system, and it is our contention that users should be afforded all of the same statutory and common law rights and protections that they currently enjoy as medical scheme members.

This clause could also have an impact on the scope of profession of a specific profession (as provided for in the Health Professions Act, 1974) in the sense that the Treatment Guidelines, as set by the Benefits Advisory Committee (Clause 25), could override the scope of a specific profession. Another impact will be by the Contracting Units for Primary Healthcare (CUP's) (Clause 37), which makes provision for healthcare professionals who were up till now (as per the Ethical Rules of the HPCSA) prohibited from certain acts, e.g. working together, sharing fees, etc. to perform those acts now. This would directly compromise patient / client care as the requirement that a person can only practice within his/her scope, and in line with his/her training, skills and experience, and also compromise the globally-accepted principle of professional autonomy.

The Bill in clause 3(5) excludes the **Competition Act**. CPSA is of the opinion that it would be better for the Bill to apply for exemption of certain provisions of the Act instead of total exclusion. Total exclusion would definitely lead to anti-competitive practices and this would have a negative effect on the Contracting Units for Primary Healthcare (CUP's) as smaller entities.

6. Children and the NHI

The registration of children is not clear. From clause 5(2) it seems that one of the child's parents must do this (*"…must register his or her child as a user with the Fund …[and] A child born to a user must be regarded as having been registered automatically").* This then raises the question as to how the child would be linked to the other parent?

Furthermore, under the Children's Act, 2005 caregivers also have the rights to give consent to treatment of children and the question is whether such caregivers (e.g. grandparent) would be in the position to register a child in his or her care? Children 12 and older are also under the Children's Act entitled to consent to medical treatment without the knowledge or consent of a parent/guardian/caregiver and would thus be allowed in terms of legislation to have access to health care under the NHI.

7. Rights and Limitation of rights

By providing in clause 6: ***"Without derogating from any other right or entitlement granted under this Act, or any other law…"*** it is made clear that the rights as afforded under the NHI Bill does not limit any other rights of persons that they may have under other laws. But then limitations are found in e.g. clause 3(3) (in case of conflict between provisions of any other law and provisions of NHI, provisions of NHI will prevail); clause 33 (limitation on medical scheme coverage) and the numerous references to only "medically necessary" care, or limitations on medicines and other health products that are accessible in the NHI, and obligations on referral pathways.

The same with the rights of children to care under section 11 of the Children's Act, in which psychologists play an important role to "promote self-reliance and facilitate active participation in the community", or the very important rights to rehabilitation current granted under the Road Accident Fund (RAF) Act and Compensation for Occupational Injuries and Disease Act (COIDA) which the NHI in the schedule to the Bill, now severely curtails.

To therefore say the NHI Fund will fund services "without derogating", whilst the NHI Bill authorises various such derogations, is in itself then a contradiction.

In clause 6(1)(a) reference is made to the entitlement of health services of ***"necessary quality".*** This differs from section 27 of the Constitution which uses the word *"reasonable".* It is unclear what the meaning of "*necessary*" will be. The Constitution grants access to healthcare in a manner that is "*reasonable*", and not only what is "*necessary*". The legal tests for "*reasonable*" are significantly lower than what would be "*necessary*". We propose that the NHI should set benefits in line with what would be **health appropriate**, with **treatment options and alternatives thereto,** that are ***evidence-based***.

Clause 6(f) provides for access to healthcare ***"within a reasonable time".*** It is not stated what is meant by reasonable time and what benchmarks will be used to determine a reasonable waiting time for services to be

rendered. It is thus unclear whether a user will be serviced in line with the urgency of his/her condition and if it will be possible to deviate from the referral pathways taking into consideration the vulnerability and dignity of the user.

Clause 6(h) awards users the right to make ***"reasonable decisions"*** about their health care. But in the NHI Fund, such decisions are curbed by referral pathways, guidelines on formularies and treatments, accreditation of facilities; whether care is complementary or NHI benefits, etc. These are limitations with regard to section 27 of the Constitution and will have to align with the provisions of section 36 of the Constitution which provides for the limitation of a right only *"…to the extent that the limitation is reasonable and justifiable in an open and democratic society based on human dignity, equality and freedom..."*

8. Health care services coverage and the role of medical schemes.

The focus of Clause 7(2) rather appears to be on **referral pathways**, or on the place where health care would be received, than on the **coverage**.of health care services. Coverage is about beneficiaries and benefits.

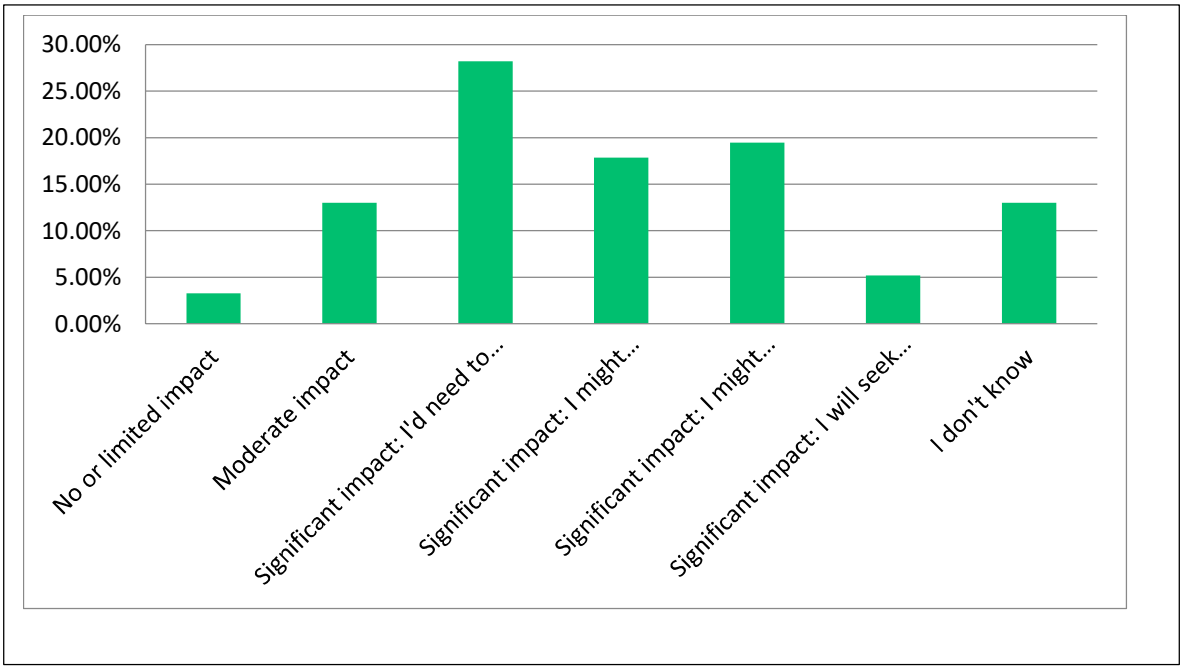
Clause 7(2)(d)(iii) refers to the implications of skipping referral pathways by stating that **where a referral pathway is not adhered to, the NHIF will not cover the care.** This then brings up the question of what would happen if the clinic (in the public health sector) or the primary care nursing professional/dental professional; general practitioner or primary allied health professional (in the private sector) decides that referral of a patient is not necessary?

Clause 33 states that a **medical scheme** may only offer "complementary services" (service benefits not reimbursed by the Fund). So, if for example a user chooses health care outside of the NHI formularies or treatment guidelines, or skipping a referral (going to which may relate to a non-contracted or non-accredited PHC provider), **would this then by definition, make the care sought "complementary"** and therefore possible for being offered as funded care by medical schemes?

Clause 7(4)(c) refers to a ***"complementary list",*** but there are no provisions in the Bill for how, when or by whom the "complementary list" will be set. Clause 7(4)(a) provides that for treatment to be funded, it must be "medically necessary" (which corresponds with clause 6(a) on the right to only have "necessary … health care services").

It is our strong opinion that only persons duly registered, trained and experienced are able to make pronouncements on care provided by others in the same professional category. If the finding is that the treatment is not medically "necessary", who will be held liable – the patient, or the provider / establishment. Would the medical scheme of the user fund such treatment as being "complementary cover"?

Our research from our members on medical schemes is also revealing. 78% of members do not support clause 33, namely that services covered by the NHI may not also be provided by medical schemes. Many questioned the exact benefits that will be covered by the NHI, and also pointed out that medical scheme cover for mental healthcare services was not optimal. Choice, as a principle, also appeared in some of the comments. Members estimated the impact of the exclusion or limitation of medical scheme benefits, thereby requiring of patients to only obtain benefits from the NHI, as follows:



Clause 8(2) states that a "penalty" that would befall a patient (and a provider) for not adhering to the NHI benefits and that in such a case the "person" or "user" would have to pay for such care out of pocket, through their medical scheme or through other health insurance, if they were not entitled to the services, did not comply with pathways, if the services are deemed not "medically necessary" by the Benefits Advisory Committee or the treatment is not included in the NHI Formulary.

CPSA has a concern regarding the *exclusive* provision of certain benefits by the NHI. It must be assumed that the NHI will not be, and perhaps may never be, in a position to provide treatment for all and every malaise or condition. It is also our understanding that there may be some form of rationing of goods and services. If medical schemes are prevented from reimbursing their members for any service provided by the NHI, what will happen as and when any user's NHI benefits are exhausted? Will there be unlimited benefits available from the NHI? What will happen if NHI funded services are not readily available within a reasonable time? It certainly cannot be intended that a person might die of a heart condition or an eating disorder whilst awaiting access to NHI services whilst private services are readily available? The exclusive right of the NHI to provide certain services to the exclusion of medical aid reimbursement also appears to limit the user/patient's right of choice. This appears somewhat Draconian and inconsistent with the Constitutional right of access to adequate healthcare.

9. Advisory Committees.

Clauses 25-27 make provision for three committees, namely the **Benefits Advisory Committee (BAC), the Health Care Benefits Pricing Committee (BPC) and the Stakeholder Advisory Committee (SAC).** These committees are appointed by the Minister of Health.

The **BAC** will determine health care service benefits, types of services to be reimbursed at each level of care, "cost-effective" and "detailed" treatment guidelines and health service benefits. The Minister of Health (a political body) and the Board of the NHI Fund, ***not*** expert advisors, will be setting benefits. Also of concern is that healthcare

professionals are not included in the setting of treatment guidelines and providing advice on benefits to be determined.

We do not have any clarity on what psychology benefits may be included in the NHI by this committee. The more that is included in the NHI benefits package, the less there will be for medical schemes and private psychology practitioners to work with.

The **BPC** sets the pricing of "service benefits", but it is not clear what this holds for healthcare providers, establishments and suppliers.

The **SAC** is made up of a wide range of stakeholders, but there is no stipulation in the Bill of what the functions of this body will be.

We are given to understand, by colleagues in other professions, that some advisory committees have already been established. We were not aware of this at this time as it does not appear to have been widely communicated across the country. We, considering ourselves to be well trained and informed about mental health matters, are most willing to participate in these advisory committee's activities and deliberations

10. Purchasing of Health Services

Clause 35(1) refers to the provision that the NHI Fund must purchase health care services ***"in accordance with need"*** on behalf of users instead of stating that services giving effect to the NHI benefits **would need to be purchased.**

Of huge concern to us, is that Section 35(2) makes **no provision** whatsoever for the **purchasing of services from private hospitals**, other units, such as physical or substance abuse facilities, **mental health facilities and specialists in private practice**, or **other healthcare professionals not working in Primary Health Care** (e.g. psychologists, occupational therapists, physiotherapists, etc.). This is in contrast to section 41 that allows for these entities to be paid an "all-inclusive fee".

We have a concern that any system of all-inclusive payments to clinics, hospitals or General Practitioners based on the number of users registered with them (a capitation basis) cannot make provision for psychology practices. Whilst almost the entire population may need to make use of a General Practitioner from time to time, the same cannot be said to be true of psychologists. A significant number of our members canvassed during the drafting of this submission also expressed concern regarding their livelihoods and ability to remain in practice. Without any clarity as to the funding model for mental health practitioners in private practice, it is difficult to either support or comment on the payment model.

The second problem with section 35(2) is that it lists **district hospitals**, which should be according to section 37, be included in primary care provision, as part of the Contracting Units for Primary Health Care (CUP's). It must also be noted that the specialized hospitals are not included in the sections dealing with the "autonomous" and "semi-autonomous" nature of public sector hospitals.

11. The Role of Psychologists in Contracting Units for Primary Health Care.

There is no reference as to where we as Psychologists will fit in primary health care in the Bill. In the survey done amongst our CPSA and EPASSA members, it was found that 74.27 % are unsure about the future of their profession, as only the role of clinical psychologists and registered counsellors are recognised by the NHI when considering mental healthcare. Not recognizing the role of Counselling or Educational psychologists, has the capacity to abolish small private practices, limit access to treatment and in the place then provide a clinic system that does not have the deeper access into communities as the current individual private practices have.

PHC services include *inter alia* promotion of good health and the prevention of health problems. The WHO gave the following explanation on this by stating: *"evidence-based prevention and health promotion is the conscientious, explicit and judicious use of current best evidence to make decisions about interventions for individuals, communities and populations that facilitate the currently best possible outcomes in reducing the incidence of diseases and in enabling people to increase control over and to improve their health (Hosman & Jané-Llopis, 2005)*[6].(Emphasis provided).

The experiences of psychologists in terms of payments by statutory bodies, whether the Compensation Fund, RAF and even where there are public-private partnerships do not instil trust in the ability to be paid timeously. Where are members would provide services as part of a Contracting Unit for Primary Healthcare, which would be organised as sub-district level, it would mean that there are systems and resources in place to ensure that in all 52 districts timeous payment (and associated accountability) are in place.

12. Organisation of the provision of health services and Transitional Arrangements.

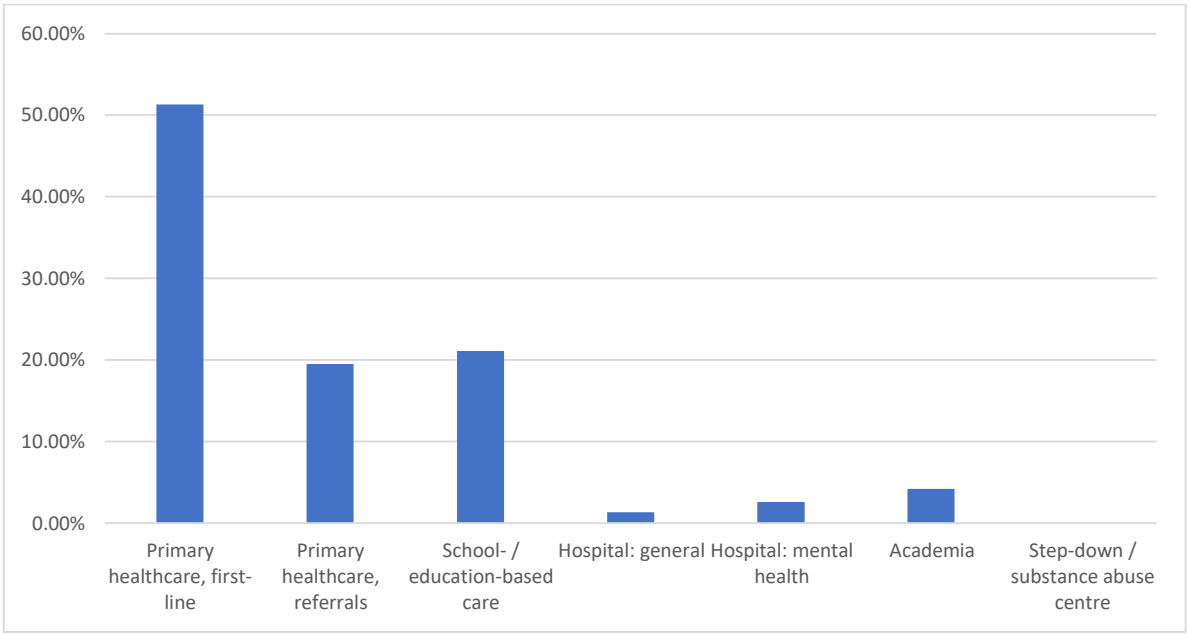
Clause 57(2)(iv) provides for the purchasing of *"personal health care services for vulnerable groups such as children, women, people with disabilities and the elderly."* We are of the opinion that this should be re-worded to include *"people with **mental and physical** disabilities."*

Clause 57(4)(f) provides for the purchasing of health care service benefits from contracted public and private providers and we recommend the inclusion of registered psychologists in the list of designated providers.

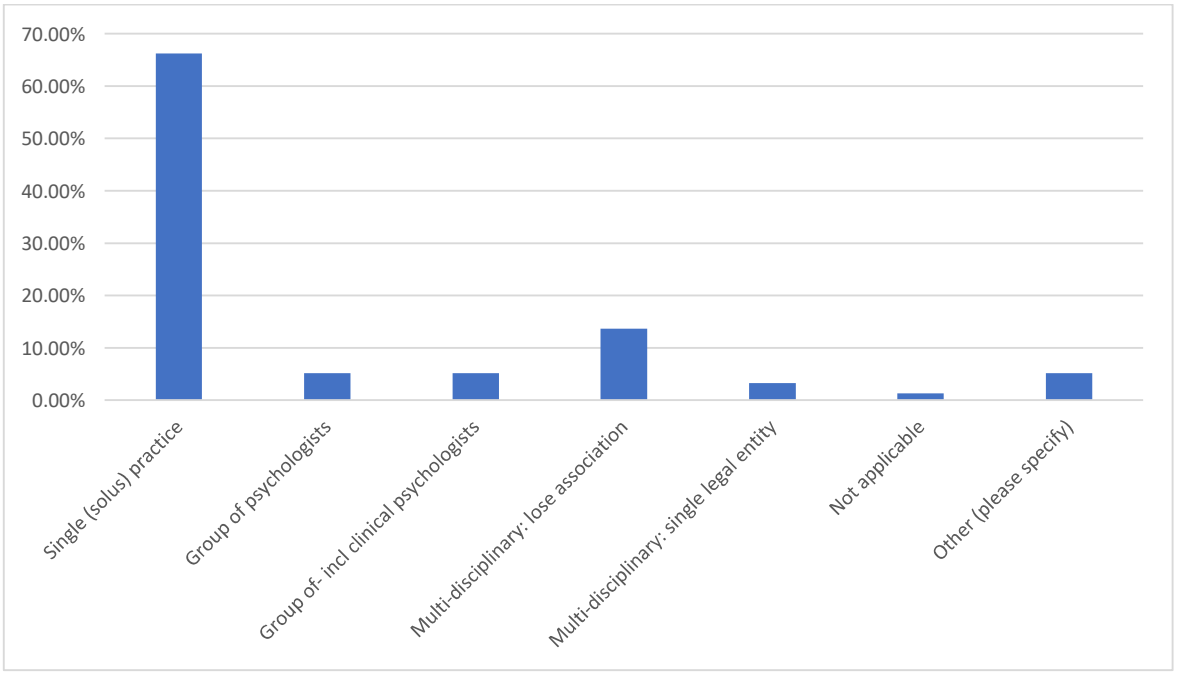
We have the following suggestions with regard to the levels at which Psychological services could be offered and which should be recognised in the Bill by inclusion of counselling services as under the various services as outlined below.

The survey undertaken by counselling and educational psychologists shows that 51,3% of respondents were working in primary care settings as first-line practitioners, whilst close to 19,5% worked from referrals. This also highlights the importance of input into- and clarity on referral requirements in the NHI, as a "referral-based only" approach to counselling and educational psychology would impact a significant number of practices.

[6] Hosman C, Jane-Llopis E & Saxena S, eds (2005). Prevention of Mental Disorders: Effective Interventions and Policy Options. Oxford, Oxford University Press (who.int/mental_health/evidence/en/prevention_of_mental_disorders_sr.pdf. Visited 16 November 2019).



Only 1.3% were working in a general hospital setting, and only 2.6% in a mental healthcare facility. Just over 4% are in academia. Interestingly, no respondents were working in substance abuse centres.



The Contracting Units for Primary Health care services (CUPS) requires in clause 37(2) networks of private providers integrated into the public health system "in a geographical sub-district area". This requires, in sub-clause (h), an "integration" of public and private health care services". No, or very limited integration exists at present, and our survey shows that the bulk of respondents in counselling and educational psychology work in single person

(solus) practices (over 66%). Only some 10.3% are in practices with other psychologists and only 15% work in multi-disciplinary practices, with a minority (3,25%) in a single legal entity, which would facilitate easy contracting into a CUPS.

Therefore, the transitional measures have to consider how the *status quo*, of mostly independent, individual practitioners are to be integrated into the business models (provided HPCSA approval is obtained for this) that could more easily contract into a CUPS.

No provision whatsoever is made for psychology services in hospital-settings, and clause 41(3) only refers to "specialists and hospitals".

Significant uncertainty exists where psychologists work for the Department of Education, or otherwise in the educational sector – will, or won't this be included under the NHI? The same applies to psychologists working in Correctional Services.

12.1. Our proposed involvement in the NHI: At Community-based Care Level

Users should be afforded the opportunity to approach a psychologist of their choice, active in their community, who is trained, experienced and skilled in the treatment of their presenting mental disorder as a first-line intervention without the need to approach a GP, clinic or hospital in the first instance as is currently the case in the private healthcare sector. This model appears to work eminently well in this sector. Unlike GP's, who are generalists, most psychologists are not trained, skilled or experienced to treat every mental disorder in similar fashion to medical specialists. Most psychologists choose to focus on a range of mental disorders in certain populations, whether it be with eating disorders, health psychology interventions, psychiatric disorders, substance abuse, or personality disorders, amongst younger populations, geriatric populations or the LGBT community. Some patients also prefer to see a psychologist with similar values to theirs, such as similar religion, gender or gender orientation.

12.2. Our proposed involvement in the NHI: At district level

At this level we can provide basic psychological assessment and therapeutic services (before hospital level as described above) and refer more serious cases to a district hospital. This could also include preventative interventions as e.g. anger control, anxiety management, health psychology interventions, lifestyle management and other multi-disciplinary systemic community interventions such as psycho-education about mental health, alcohol abuse prevention, developing resilience and coping mechanisms to prevent mental disorders and conflict management, etc. that could be provided to improve mental health and prevent mental illness. It is a well-established principle in medical care that preventative models of care can avert later, costly intensive interventions. Early screening, preventative health interventions and community-care based interventions by both registered counsellors, psychologists and social workers will be important in reducing the disease burden due to mental disorders. In this system, patients could be seen without any referral from a general practitioner and this could assist in alleviating the burden on general practitioners.

12.3. Our proposed involvement in the NHI: At District Hospital Level

Here the Psychologist can form support of the district support team that would provide formal psychological assessment and psychotherapeutic services for users suffering from a more complex diagnosed mental disorder as a first line treatment intervention**.** These Psychologists would be senior Psychologists (Psychologists with at least 3 years registration with the HPCSA and practice experience, and also able to supervise other psychologists and

interns). They could provide consultation services to other psychologists working at district level outside the hospitals and provide therapeutic services to medical patients that may be suffering from co-morbid psychological conditions while they are being treated in the district hospital. Patients suffering from more severe forms of psychopathology, could then be referred to regional hospitals.

Psychologists practising in this setting would also apply health psychology interventions, where the practice of psychology can lead to significantly better treatment outcomes in medical conditions such as diabetes, cancer, heart disease, pain management and neurological conditions, such as multiple sclerosis. They also contribute by providing psychotherapy for patients dealing with a diagnosis of a dread disease.

12.4. Our proposed involvement in the NHI: At Regional Hospital Level

These Psychologists will treat relatively severe forms of mental illnesses in close collaboration with Psychiatrists, either as in-patients or out-patients. Specialised services such as neuropsychological services (assessment, diagnosis and treatment of psychological disorders associated with brain-based conditions) could be provided and health psychology services (focusing on a patient's mental and emotional reaction to an illness or recovery from an illness) to in-patients suffering from co-morbid psychological conditions as described above in paragraph 12.3.

12.5. Our proposed involvement in the NHI: At Tertiary/Specialist Hospital Level

They treat severely disturbed patients as in-patients being treated in specialist psychiatric hospitals and/or private acute psychiatric clinics in consultation with Psychiatrists, and could provide specialised services such as forensic and neuropsychological services in accordance with the National Standard Treatment Guidelines published by the National Department of Health.

We are in the position to provide the services as mentioned above because it is beyond the scope of registered counsellors or social workers to provide these services at this level. It is well within the Scope of Profession of psychologists, their training (both practical and academic) and post-Masters Continuing Professional Development (CPD) training.

13. Accreditation of service providers

"Accreditation" is defined in the NHI Bill as *"being in possession of a valid certificate of accreditation in terms of section 39".* Throughout the Bill, where contracting, procurement and payment are concerned, much is made that the service providers and establishments must be "accredited". It is assumed that this refers to the process of application, possible inspection and compliance with stipulated criteria, capacity in the NHI Fund, and a budget, for the development of this system, and adequate human resources to manage it. According to Medpages,[7] there are 8 043 mental health practices, 26 100 medical professionals (Psychiatrists, etc) and 7 672 mental health professionals (psychologists, etc). The processing of all these application forms could take years.

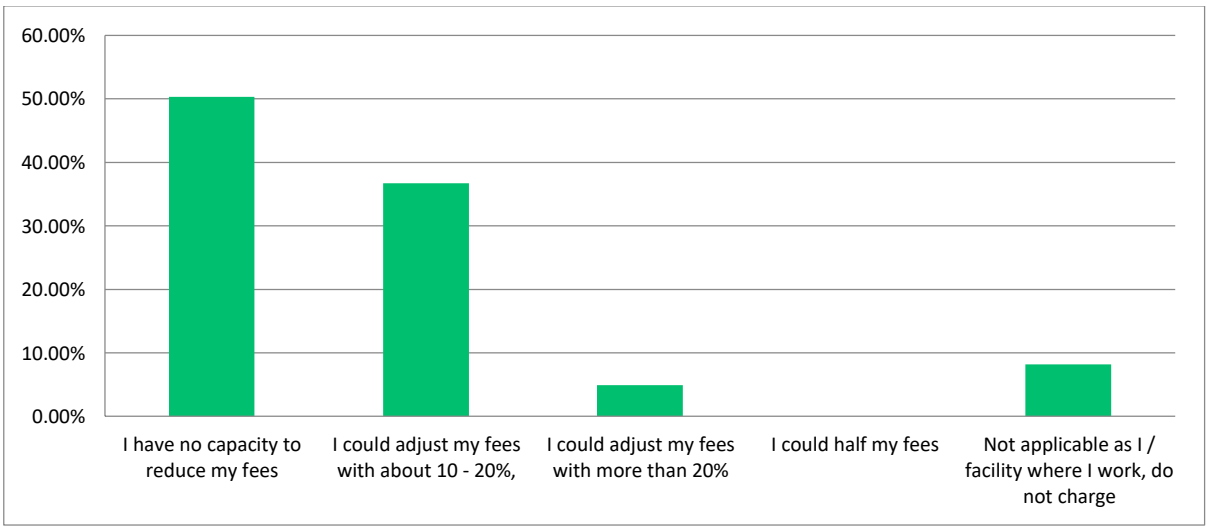
Clause 39 appears to attempt to implement parts of the Certificate of Need, but just without the legal requirements and within some of the checks and balances (such as practice viability) found in the NHA. Clause 39(8) provides for an accreditation to be withdrawn if the conditions are not met, continuously. What is noteworthy is that it is not just a "failure" but also "inability" that could lead to the withdrawal of accreditation. These clauses are also open to

[7] https://www.medpages.info/sf/index.php?page=stats (Visited 18 November 2019)

corrupt practices in such a system. This may also, in fact, enable the closure of public facilities where private facilities exist and then simply transfer responsibility of care from the state to those private facilities or vice versa.

14. Payment of health care service providers.

The extent to which the NHI Bill introduces uncertainty in the field of psychology is clear from our survey, in particular as 61% of respondents only work in the private sector, with 10% working in the private sector on RWOPS (remunerated work outside of the public service). What is also noteworthy is that many psychologists apart from their main setting of work in either the public or private sectors, also work in non-governmental-, welfare-, remedial, religious-and community centres. It is therefore not surprising that, given where psychologists mostly practice (in the private-, education- and NGO sectors), the "still to be determined" nature of "payment mechanisms" and "additional mechanisms" as per clause 41(1), overall sentiment from our members on the NHI is neutral to negative, at over 77%.



Members are uncertain how they will be compensated and **74.27 % are not sure how their private practices would fit into the implementation of the NHI** (as mentioned in paragraph 3.11). Furthermore, **28.34% indicated that there will be a significant drop in their income** as the largest part of their income comes from medical schemes, as medical scheme cover will in future be excluded from services covered by the NHI, at probably much lower rates than current scheme rates. In terms of the potential to drop fees in response to the NHI, which in all likelihood will be able to pay less than what medical schemes currently can, there appears to be limited scope for such price reductions, in all likelihood no more than 10 – 20% for some, but not all, psychologists.

Given that most psychologists in private practice indicated that they set their fees in line with what their patients' medical schemes pay, this margin for potential fee reductions may not be achievable, unless savings such as administration costs could be realised through the reorganisation of the sector into multi-disciplinary, larger entities. Such a reorganisation will, however, take time, much longer than the 2026-implementation date for the full NHI, and definitely not within the deadline set for full CUPS (primary healthcare) implementation. A minority (close on 32%) practitioners however indicated that they envisaged employing other healthcare professionals, merging with other practices or changing their business models in the future. If they had to, the preferred business model appears to

be independent contractors in large multi-disciplinary practices (81%) or for a corporate entity (clinic, hospital, or educational institution) (76%). However, employment by these entities is definitely not favoured.

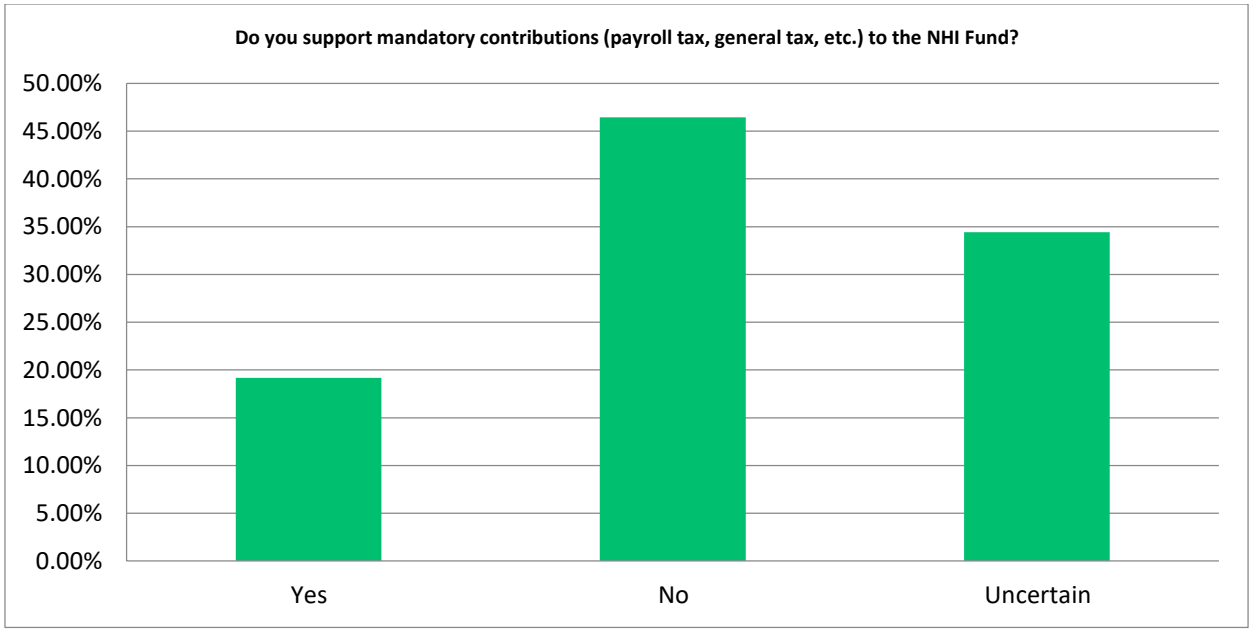
A further assumption being made around the NHI is that there is, and will be, increasing spare capacity from private sector providers to contract into the NHI. with close to 65% of respondents already working from 40 hours to over 60 hours per week. With close to 54% of respondents indicating they only have 1 to 8 hours spare capacity per week. Growing capacity in the public sector is also reported as constrained: just over 25% of respondents said there were no public sector positions available, 16% said there were vacancies, but the positions were not filled, with 4,2% saying they could not find candidates to fill vacancies.

In the absence of any detail as to the financial model as to how service providers, other than GP's, clinics and hospitals, may be reimbursed, (fee for service, global fee arrangements, capitation-based payment, etc.) it is difficult to comment on the financial impact that NHI will have on the sustainability of psychologists' practices. The current system of reimbursement by medical aid schemes works very well. The claims submission process, tariff rates, coding and payment mechanisms are well understood. Section 59 (2) of the Medical Schemes Act, 1998 imposes a duty on medical schemes to pay either the service supplier of medical scheme member within 30 days of the date of service. It is hoped that there will also be some form of duty on the NHI to timeously reimburse psychologists in terms of whatever payment model is developed. Our members' experience of rendering services in terms of the Compensation Fund is that healthcare practitioners frequently wait up to between six- and twenty- four months for payment for services rendered to injured or ill employees. If the NHI functions in any way remotely similar to the Compensation Fund, the healthcare industry will be unsustainable and collapse.

It is also hoped that the Health Care Benefits Pricing Committee (BPC) will use a rational, scientific basis to determine the actual costs (Based on Relative Units of Value as was done when the National Health Reference Price List - NHRPL - structure was still in effect) of running a psychology practice, and a fair remuneration for psychologists, given the years of study and level of fiduciary responsibility that they bear for patient's' interests.

15. Funding of the NHI

In spite of this actually belonging in the Money Bill as envisaged by the Constitution, as it relates to the levying of taxes, clause 49 nonetheless describes the sources of income of the NHI as general tax revenue, the removal of tax credits, payroll taxes and a surcharge on personal income tax.



Our members' views on the introduction of a payroll tax were as follows:

One of our members stated: "It concerns me that the NHI is a theoretical concept that will require funding well beyond what is possible in a country where so few taxpayers contribute". This view aligns with the findings of the Davis Tax Committee on the NHI in 2017, the Financial and Fiscal Commission's statements in Parliament to the Health Portfolio committee on 15 October, and the Medium-Term Budget Policy Statement of the National Treasury, presented to Parliament on 30 October 2019:

"Originally, NHI costs were projected to increase public health spending from about 4 per cent to 6 per cent of GDP over 15 years. However, given the macroeconomic and fiscal outlook, the estimates to roll out NHI that were published in the NHI Green Paper in 2011 and White Paper in 2017 are no longer affordable."

Notwithstanding this reality, and the risk of the NHI Fund being subjected to legal cases based on the promises for comprehensive cover, the NHI Bill is being processed virtually as it was envisaged in the NHI White Papers. There is a lack of mechanisms or criteria according to which access rights, and funding (social security) rights could be limited in a manner that is reasonable and justifiable, as is required by the Constitution. Instead, and unfortunately so, the Bill makes promises, which promises are being re-enforced during the provincial hearings on the NHI, of enhanced quality of care, enhanced benefits, etc.

There are no provisions similar to those limiting healthcare rights towards medical schemes (e.g. that only catastrophic care, or hospital-based care are to be funded as mandatory), or in the National Health Act's section 4, that prioritises maternal and child health, as well as reproductive care. This is in spite of political indications that primary healthcare, and care for vulnerable persons, which we would deem to include mental healthcare, care for children and the elderly, should be included, these principles have not found its way into the NHI Bill.

16. Concerns Regarding Corruption and Bureaucracy.

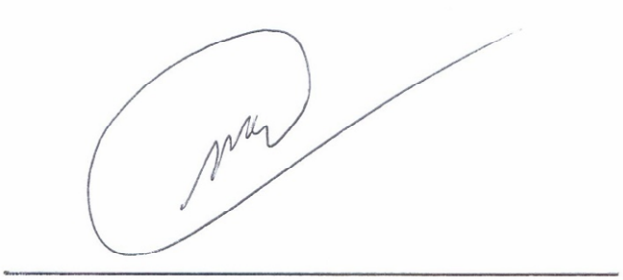
Our members have expressed concerns regarding the security of funds paid into the NHI, payment processes, etc. There is a litany of qualified audits issued by the Auditor General, citing billions of Rand that cannot be accounted for by both government departments and State-owned Enterprises. Whilst the Hon President has indicated that NHI funds will be closely guarded, the Auditor General's findings into the Department of Health, amongst others, potentially suggest otherwise. The loss of funds also seems to be accompanied by a lack of accountability, that where qualified audits are issued little disciplinary, criminal investigation or sanction seems to follow.

Secondly, concerns have also been raised that the implementation of NHI may lead to another over-populated bureaucracy that will use up funds for operating costs and salaries that were intended to fund services by healthcare practitioners. Current medical aid schemes have relatively small, lean administration structures and are subject to rigorous controls that are not typical of the State sector.

17. Conclusion.

We would also welcome the opportunity to make a verbal submission to the portfolio Committee and remain willing to provide further information to the Committee about our fields of work.

Yours sincerely



M. A. Webber (NO[8])

President CPSA

We can be contacted at:

President: president@cpsychsa.org or 021 554 0075
Vice President: vc@cpsychsa.org
Executive Officer: exec@cpsychsa.org

[8] *Nommino Officium: In this and every other document, this abbreviation indicates that this executive member of CPSA is acting in his/her capacity as executive member and is in total not responsible and therefore indemnified in his/her personal capacity.*