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Psychological Society of South Africa

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Director General of Health
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Dear Ms. Matsoso

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

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

PsySSA was formed in 1994 and is the representative body for psychology professionals in South Africa. PsySSA is a registered non-profit organization and a voluntary professional association with over 1800 members, 11 special interest divisions, 12 standing committees, provincial branches, with oversite by an Executive and Council. PsySSA membership includes all categories of psychologists (clinical, educational, counselling, research and industrial), psychometrists, registered counsellors, and students. We are a non-partisan, unifying organization for all psychology professionals that seeks to advance South African psychology as a science and profession of global stature, and promote psychological praxis which is relevant, proactive and responsive to societal needs and well-being. PsySSA therefore has a vested moral, social and clinical interest in the NHI generally, and in related psychological services more specifically.

There is no doubt that our health system needs dramatic reforms at every level to undo the inequity in access to health care, which is borne from the enduring legacy of apartheid. The current process presents an opportunity to step up implementation of policy commitments for health and mental health to improve

service access, delivery and outcomes. PsySSA supports the spirit of the NHI Bill and its principles, goals and objectives. We support universal health coverage and the idea that health care should be viewed as a social investment for a healthy and productive society predicated on equity and social justice. We wish to convey our willingness as the representative body for psychology professionals in South Africa to contribute to the development of the NHI system by providing input to all processes related to the NHI. Our members have extensive clinical, research, management and social responsiveness skills required in establishing and implementing the work of the NHI Fund

As mental health professionals, we commit in particular to providing input relevant to supporting a health care system which will improve access to mental health care in South Africa. Our specific comments to the Bill are contained in Table 1 below. We make these comments mindful that:

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

2. The NHI Fund should offer our country the opportunity to develop and implement interventions focussed on three mental health related issues, i.e. (1) promotion of healthy lifestyles and *mental wellbeing and within communities*, and not only within health facilities; (2) more robust embedding of a *mental health orientation to physical health* promotion and treatment services; and (3) *providing adequate mental health services* for people with enduring mental illness (psychosocial disability) within our health system.

2.1 *Mental wellbeing within communities*: There is extensive international and local evidence pointing to the fact that the high levels of poverty, continuous trauma and constraints to social and economic development faced by many South Africans erodes psychological health and inhibits the resilience needed to cope with and overcome these stressors. The current traumas experienced by citizens due to gender-based violence, family murders, attacks on thriving community businesses and infrastructure, living in violent neighbourhoods, and the mental strain experienced by South Africans due to state capture and increased economic vulnerability of our country, to mention a few, serve as solemn reminders of ***the need to employ psychological interventions and skills to rebuild a healthy, resilient national psyche***.

2.2 *Mental health orientation to physical health:* The link between mental and physical health is now well established: people with poor mental health are less likely to live healthy lifestyles, impacting on their physical health (and need for health services), while people with physical health

conditions (including priority conditions such as HIV and AIDS, tuberculosis, and CVD) may develop depressive and anxiety related conditions secondary to their physical health condition, impacting on treatment compliance capabilities, and recovery rates. ***Greater attention to mental health status in delivery of physical health care will be both health promoting, and cost saving***.

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

2.4 The SAHRC report makes special mention of the need for attention to the mental health and wellbeing of children and adolescents. The mental and physical health and wellbeing of children and adolescents (CA) should be a prime focus of our health efforts. Schools are an important setting within which to introduce interventions aimed not only at prevention and cure of illness, but also programmes to develop the values, attitudes and behaviours that promote resilient citizenship of children, and their families. Key partnerships with, for example, the Departments of Basic Education, Social Development, Justice, and Economic Development at local level are important to reach out CA, families in crisis, CA in conflict with the law, and adolescents ready for gainful occupation, as an extension of community-oriented health promoting schools initiatives**.** ***Current Health Promoting Schools initiatives should be strengthened and reviewed as a framework and vehicle for delivery of a more comprehensive school health programme countrywide. This programme could be linked to the Screening, Identification, Assessment and Support policy of the Department of Basic Education.***

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

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

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

General remarks:

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

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

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

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

General remarks:

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

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

		young adults turning 19 still dependent on their families will suddenly be without healthcare. Universal health care should be provided to all human beings who require it, including asylum seekers and illegal foreigners. Alternative billing arrangements can be made between the Fund and the relevant home countries of asylum seekers and illegal foreigners. This point is especially important in the context of mental health care. Many asylum seekers and illegal foreigners suffer from depression, anxiety and trauma, having left their home countries under duress, only to live in this country under severe economic hardship and the continuous threat of xenophobia and violence. Affording them only emergency medical services does not make sense. For example, it is easier and cheaper to treat a person with mild depression as an outpatient, than to wait for the condition to worsen to severe depression with suicidal ideation and psychotic features, which will be considered emergency services, but be far more costly to the Fund, requiring admission and more intensive treatment. It would also be unethical and nonsensical to then not offer any follow-up services after offering the initial emergency services.
5.1 line 47 And 5.8 And 6.d-f	(5) 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 <u>or (d) an</u>	Many South Africans still do not have identity documents, or a person might have lost their documents and, in some cases, children do not have documents due to their parents not having documents to use to obtain these. Provision must be made for temporary access to services while formal registration documents can be procured.

	affidavit of citizenship to obtain a temporary access card (or similar) (8) A user seeking health care services purchased for his or her benefit by the Fund from an accredited health care service provider or health establishment must present proof of registration or temporary access card to that health care service provider or health establishment when seeking those health care services	The NHI Bill must make provision for access to service provision in the event that the person cannot be registered for some reason, or is awaiting registration, to avoid any instance of administrative injustice. Registration of users should also not be dependent on providing *proof* of habitual place of residence (S5.5) due to high rates of homelessness, urban migration, and informal settlements in South Africa. It is of concern that the rights of users to health care services is "within the State's available and appropriated resources" (S6). If the Fund is the only purchaser and provider of services, given the severe limitations imposed onto what medical schemes can and cannot offer, we are concerned about how services will be prioritized and/or rationed, in the event that resources and tax income streams do not meet the expected levels. It should be specified what "a reasonable time period" (S6f) is within which a user can expect to access services, given the long waiting lists currently in place at public hospitals.
Rights of users 6	Rights of users S6 (d) not to be refused access to health care services on unreasonable grounds; S6 (f) to access health care services within a reasonable time period…	It is unclear how "*unreasonable grounds*" and "*reasonable time periods*" will be operationalized. Access to mental health services (particularly in emergencies such as suicidal/homicidal ideation/psychosis) needs to be immediate. Similarly, MHCUs presenting with common mental disorders (such as anxiety and depression) need to access health care services without delay, as these common mental disorders can quickly escalate into medical emergencies.

7.4 (a) – (d)	Amendment needed to section copied below: …a health care service provider ...demonstrates that *(a)* no medical necessity exists for the health care service in question; *(b)* no cost effective intervention exists for the health care service as determined by a health technology assessment; or *(c)* the health care product or treatment is not included in the Formulary, except in circumstances where a complementary list has been approved by the Minister	Lack of clarity regarding whether 'health care provider" refers to the referring or referred to provider. In some instances, assessment requires specialist assessment to identify and prescribe treatment and there is a risk that users may be turned away before adequate assessment has been conducted. This is the case for mental health disorders, where competence in the primarily health system is limited for detection and treatment. The health technology assessment tools will need careful integration of mental health disorders. Similar difficulties, for example are currently being experienced by users with serious mental illness wanting to access social assistance where tools focus on physical health, and poorly detect mental health conditions. Point (b) requires urgent attention to the determination of "cost effective interventions" Point (c) demonstrates the need for inclusion of mental health professional in the determination of the Formulary. Under NHI, service users should have the right to a second opinion. In terms of the existing Patient Rights Charter, users have the right to "Choose their own health care provider or health facility" and "Be referred for a second opinion to a healthcare professional of their choice." Research shows that where service users participate in decisions made about their care, adherence, compliance, and mental health outcomes are improved.
7.5 (a) – (d)	… provide the user with a reasonable opportunity to make representations in respect of such a refusal; *(c)* consider the representations made in respect of paragraph *(b)*; and *(d)* provide adequate reasons for the decision to refuse the health care service to the user.	The average South African is unlikely to be in a position to make representation to the Fund, raising ethical and human rights concerns. Legal opinion should be sought before inclusion of (d), as the board or its medical representatives would need to make these judgments based on other health professional reports, not on direct assessment

		of the patient, potentially a source of malpractice, and suing of the Fund (high risk approach).
CHAPTER 3: NATIONAL HEALTH INSURANCE FUND **General remarks** • There is, overall, a worrying amount of, centralisation of power and decision-making and diminished service user autonomy, in the manner in which the Fund has been conceptualized. We hope that the Fund does not create an unwieldy, cumbersome, inaccessible, bloated bureaucracy which even further disconnects users from action-decision making around their own health-care needs. • It is essential that research, monitoring and evaluation of the impact of the Fund on national health outcomes include mental health indicators, and include psychologists in the conceptualization, design and implementation of such studies.		
Section	**Comment/ Proposed changes (underlined)**	**Justification for change**
13 (5) (b)	*(b)* have appropriate technical expertise, skills and knowledge or experience in health care service financing, health economics, public health <u>programme development and</u> planning, monitoring and evaluation, law, actuarial sciences, information technology and communication. It is recommended that the Board include a public mental health specialist (S 13.5b) given its wide-ranging powers and functions (S 15).	Care should be taken to include expertise of the actual mental and physical health programme development and implementation. Health committees tend to include support expertise (finance, M&E, IT, ICT, etc.) with much less attention to the goodness of fit of these with the actual programmes (interventions) delivered to users. Also, unlike other priority health programmes (e.g., TB dots, HIV, eye care, etc.) there are no national mental health programmes specifically developed and implemented in our local context at the present time.
CHAPTER 5: **General remarks:** • It is essential that the appointment of the CEO be a person with impeccable moral integrity, exceptional technical expertise in managing such a large Fund, and has the necessary emotional intelligence to be a transformative leader. This will ensure greater public buy-in, confidence, and trust in the NHI.		
20 (e)	establishment of an Investigating Unit within the national office of the Fund for the purposes of— (i) investigating complaints of fraud, corruption, other criminal activity, unethical business practices and abuse relating to any matter	The fund cannot investigate itself; therefore, the fund must be subject to the same external scrutiny that any other public structure is subject to under the law.

	affecting payees or users of the Fund; and (ii) liaising with the District Health Management Office concerning any matter contemplated in subparagraph (i)	

CHAPTER 6:

General remarks:

- Given that, unlike physical health care, programmes (and benefits and equipment) for mental health care, and psychological care within this ambit, are still poorly explicated, it would be advisable to convene a Psychological Services Technical Committee to advise the Board. If a broader Mental Health Technical Committee is established instead, it is essential that *practising* psychologists involved in delivering health care services are included in this Committee.

CHAPTER 7:

General remarks:

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

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

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

CHAPTER 8:

General Remarks

a) Given the extensive role of the National Department of Health, it is essential that mental health be kept on the agenda and psychologists be called up to advise on their functions e.g. such as in issuing and promoting guidelines for norms and standards related to health matter (S 32a) or planning the development of public and private hospitals (S 32d). It is often the case that psychological services are not catered for by design, and this can be prevented by including psychologists in formative discussions from the outset.

b) The National Health Information System (S 34.1) must include comprehensive mental health indicators.

Section	Comment/ Proposed changes (underlined)	Justification for change
31 (2) Chapters 4-6	(2) The Minister must clearly delineate, in appropriate legislation, the respective roles and responsibilities of the Fund and the national and provincial Departments, taking into consideration the Constitution, this Act and the National Health Act, in order to prevent duplication of services and the wasting of resources and to ensure the equitable provision and financing of health services. A mechanism (high level task team must be established in the Ministers office during phase I to assist the minister to effect section 31 (2).	It is of concern that the Minister of Health, as an individual, is at the epicenter of most decision-making regarding the Fund, and will wield an inordinate amount of discretionary power over the entire health care system in South Africa. Despite the checks and balances put in place to curb the abuse of power and/or the dangers of state capture seen in so many recent political appointments, it is essential that more impactful mechanisms be written into the Bill so that related advisory committees and civil society more broadly can influence Ministerial decisions.

		The provisions for the establishment of the Fund Board, Fund management and employees, and infrastructure is extensive and likely to utilize a substantial port ion of the health budget intended for health services for citizens. There are no indications in the Bill on how the minister will address the matter of expenditure control of the Fund.
32	(a) issuing and promoting guidelines for norms and standards related to health matters;	Guidelines need a clear and distinct timeframe. The need for norms and standards in the field of mental health has been communicated to National DOH over the years with no outcome. The lack of appropriate norms and standards has serious implications for staffing and budgets, which negatively affects service provision.
32	(b) implementing human resources planning, development, production and management;	The moratorium on (mostly allied health and admin support) posts (including psychologists) in many provinces suggests that at present, the DOH is unable to effectively manage human resources in the public sector. This does not inspire faith that DOH will effectively be able to manage this process in the future.
33	Once National Health Insurance has been fully implemented as determined by the Minister through regulations in the *Gazette*, medical schemes may only offer complementary cover to services not reimbursable by the Fund, <u>except in circumstances where a complementary list has been approved by the Minister permitting formulary services to be provide by private health scheme where this support may be in the best interests of users of services, and to promote public private partnership.</u>	This shows a more systemic problem, whereby the role of medical schemes needs far greater clarity given that the majority of psychologists work in private practice and rely on medical schemes for their income. The Department needs to be far clearer on the real-world implications of this on private health professionals and service users, to curb the fear, anxiety and paranoia about future employment opportunities in South Africa. To prevent a massive brain-drain, the Department needs to clearly stipulate, early on, how the NHI Bill will impact income-generation, employment, and private practice. During the establishment of the NHI, it would be useful for legislation to permit some flexibility in utilization of the country's full complement of services providers, to ensure that public and private service provision is supportive of access for users, and that no unnecessary service gaps arise during the "teething" period of the new system. Otherwise if health care practitioners are not

		accredited – they will effectively be unable to work as the Fund will eventually cover most aspects of health care. The suggested amendment would provide the Minister, and the Fund with the necessary flexibility in the first period of implementation of the new system, and to better explore options for public private mix, as required in section 37 (2) (h)
34	National Health Information System	There are many public hospitals and clinics that have had no access to email or intranet for upwards of 2 years. Without concerted effort in line with proper infrastructure, these systems will fail before they have even started.
35.1	Diagnosis Related Groups	Psychologists and other mental health professionals must be included to provide inputs relating to mental health Diagnostic Related Groups. The purchasing of health care services, if it is to be active and strategic, must consider the DALYs caused by mental illnesses and related burdens of disease. As it is currently stated, "*in accordance with need*" raises questions of definition: how is "*need*" determined and who determines this? Emergency medical services (mentioned in S 35.4a) must include psychiatric and psychological emergencies, such as suicidal- or homicidal ideation, aggressive behaviour, substance misuse, and psychosis.
37	Health promotion & prevention – funding and provision	It is unclear how health promotion and prevention needs will be determined. Given the lack of public awareness regarding mental health, and the ongoing stigma experienced by service users with mental illness, psychologists and other mental health professionals need to be actively involved in determining health promotion and prevention needs. Registered counsellors can also contribute enormously to the provision of mental health promotion and

		prevention and should be effectively utilised in the health care system.
Office of Health Products Procurement S38	(4) The Office of Health Products Procurement must support the Benefits Advisory Committee in the development and maintenance of the Formulary, comprised of the Essential Medicine List and Essential Equipment List as well as a list of health related products used in the delivery of health care services as approved by the Minister in consultation with the National Health Council and the Fund	What processes can be implemented to review the Formulary and what are the time frames? Inputs from mental health professionals are required in this regard. Psychometric equipment, play therapy equipment, etc. must be included in the Essential Equipment List.
Accreditation of service providers s38	(b) meet the needs of users and ensure service provider compliance with prescribed specific performance criteria, including the—…	This raises questions on how the fund will monitor this. Without clear guidelines, in light of our susceptibility to corruption, this is both inefficient and unethical practice. Perhaps this might be within the prescripts of the HPCSA?
38	(4) The contract between the Fund and an accredited health care service provider or health establishment must contain a clear statement of performance expectation and need in respect of the management of patients, the volume and quality of services delivered and access to services	Again, there needs to be clear indication of how the fund will monitor this.
38	(6) The performance of an accredited health care service provider or health establishment must be monitored and evaluated in accordance with this Act and appropriate sanctions must be applied where there is deviation from contractual obligations as per the law.	This must be done by an independent body, such as the HPCSA or OHSC.
38	(8) The Fund may withdraw or refuse to renew the accreditation of a health care service provider or health establishment if it is proven that the health care service provider or health establishment, as the case may be— (a) has failed or is unable to deliver the required comprehensive health care service benefits to users who are entitled to such benefits; (b) is no longer in possession of, or is unable to produce proof …	This has the danger of being paternalistic and top-down. This does not effectively deal with the unique governance of professional occupation bound of scope. Accreditation needs to be facilitated by health care practitioners in that specific clinical discipline – it does not make sense to have (for example) a medical practitioner accrediting a psychologist.
38(3)	The Office of Health Products Procurement	The Office of Health Products Procurement (S 38) must be incorruptible given the centralised public procurement of health

		products. A set of essential psychological assessment tools for use in both general mental health service settings, and forensic mental health settings will be required and should be included in Office of Health Products Procurement's selection of health-related products to be procured for the Essential Equipment List. Psychologists to be included (advisory capacity, contracted member to the Office of HPP) to ensure adequate inclusion of required assessment tools on the Essential Equipment List and within procurement processes. Child Intervention equipment must be included in the national health products list (S 38.3b).
39 (6)		Greater clarity is needed on how accredited health care service providers or establishments will be monitored and evaluated. It is recommended that research psychologists with expertise in public mental health be considered key stakeholders or preferred candidates for the appointment of such monitoring roles.
40	(c) the information is required by an accredited health care service provider, health establishment, supplier or researchers for the lawful purpose of improving health care practices and policy, but not for commercial purposes.	This immediately raises serious ethical concerns on informed consent. How will the Fund ensure ethical and methodologically rigorous research?
41	Review of the payment of health care service providers.	It is essential that payment of health care service providers be on par or exceeds current levels of reimbursement to prevent a brain-drain and promote the wellbeing of health professionals.
42	(2) The Investigating Unit established by the Chief Executive Officer in terms of section 20(2)(e) must launch an investigation to establish the facts of the incident reported and must make recommendations to the Chief Executive Officer as to the way in which the matter may be resolved within 30 days of receipt of the complaint. This investigating unit must be a	The Fund cannot investigate itself. This opens up the possibility of corruption in the absence of transparency.

	separate body – otherwise it will cause severe ethical issues around transparency.	

CHAPTER 9, 10:
No specific comments

CHAPTER 11:

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

57.3(c) and (d)	Mental health representation is requested on the following preliminary committees in phase 1: "The Ministerial Advisory Committee on Health Care Benefits for National Health Insurance, which must be a precursor to the Benefits Advisory Committee and which must advise the Minister on a process of priority-setting to inform the decision-making processes of the Fund to determine the benefits to be covered. *(d)* The Ministerial Advisory Committee on Health Technology Assessment for National Health Insurance, which must be established to advise the Minister on Health Technology Assessment and which must serve as a precursor to the Health Technology Assessment agency that must regularly review the range of health interventions and technology by using the best available evidence on cost-effectiveness, allocative, productive and technical efficiency and Health Technology Assessment"	Specialised mental health (including psychology input will be required for deliberations of the Ministerial Advisory Committee on Health Care Benefits (later the Benefits Advisory Committee), the Committee on Health Technology Assessment (later the Health Technology Assessment agency), to ensure that benefits include appropriate mental health /psychological assessments, interventions and equipment, and can advise regarding development of appropriate and necessary inclusions where they may as yet not be available. Our motivation on page 1 notes PsySSA members' willingness to provide research and expert technical input to these processes.
57.4 (f)	the purchasing of health care service benefits, which include personal health services such as primary health care services, maternity and child health care services including school health services, health care services for the aged, people with mental and physical disabilities and rural communities from contracted public and private providers including general practitioners, audiologists, oral health practitioners, optometrists, speech therapists, registered counsellors and psychologists and other designated providers at a primary health care level focusing on disease prevention, health promotion, provision of primary health care services and addressing critical backlogs…	Re: mental and physical disabilities: As motivated on page 1 and 2, in particular comment 2.3 on the SAHRC report on the status of mental health services in South Africa, there is a need for explicit mention of mental health in the bill given the tendency to focus on physical health - and neglect mental health - in the development of health strategy (despite national policies for inclusion). Re: registered counsellors and psychologists: A recent (July 2019) call for expression of interest in inclusion in a national database to provide mental health and forensic services published by the national directorate for mental health, called for submissions by registered counsellors and clinical psychologists. Similar services will be needed within the NHI Fund. We recommend the inclusion of registered counsellors and psychologists in this section, and all other sectors where health service providers are specifically mentioned by occupational group. The category of "registered counsellor" a 4-year trained health professional was specifically created to make available

		psychological services at the primary health care level, and is a post category already on the human resource establishment of the health sector. Current recommendations under consideration for the revised scope of practice for psychology describes the work of the registered counsellor and psychologists as follows: "Registered Counsellor is the entry-level category within professional psychology that offers low-intensity psychological interventions and assessment to individuals and groups to prevent and alleviate psychological challenges and /or enhance psychological functioning and wellbeing". The working group's report is available at http://www.neuropsychologysa.co.za/wp-content/uploads/2018/05/Report-of-Working-Group-on-Promulgations-of-Regulation-Feb-2018.pdf for perusal of the scope of practice of clinical, counselling, educational, research, industrial, neuropsychology, and forensic psychology on pages 22-23. The report also categorises psychological services as follows, which would need consideration in the Benefits Formulary (and technical input from PsySSA and the Board of Psychology would be available for this task on the relevant committees as indicated above) • Low-intensity psychological interventions are evidence-based interventions that have been modified to be delivered by registered counsellors who do not require highly specialist training to provide more accessible mental health care that reaches a larger number of people in contexts of limited resources (Bennett-Levy et al., 2010). These low-intensity interventions include guided and non-facilitated self-help, mindfulness training, behavioural activation, psychoeducational groups and other interventions that are generally very brief, usually no more than six sessions, cost effective and typically supplemented with reading material, computer-based exercises, audiobooks and audio-visual recordings.

		• Medium-intensity psychological interventions are defined as brief, evidence-based psychological therapies delivered to individuals and groups. These brief psychological interventions should usually not exceed twelve one-hour sessions and can, if necessary, incorporate, aspects of low-intensity therapies. • High-intensity psychological interventions, which can also incorporate components of low- and medium-intensity interventions, may exceed 12 sessions and are generally reserved for groups and individuals who have not or are unlikely to benefit from low- or medium-intensity psychological therapies (e.g., Clark, 2011). High-intensity therapies should draw on the relevant empirical research and should be appropriately matched to the therapist's clinical expertise and the preferences of the client. This plan will significantly improve the ability of PHC to screen and treat mental health conditions and make discerning upward referrals. Hereby, users will have access to low, medium and high intensity psychological interventions at the point closest to their home, with the appropriate psychological service provider (registered counselor and/or psychologist, depending on intensity of need).
4.3 (Memorandum)	4.3 There will be an increased emphasis on health promotion and preventive services, in addition to improving curative and rehabilitative services, <u>and promoting an intersectoral enabling environment for health in a Whole of Society approach</u>	The Bill prioritises people with disabilities, and we recommend specifically disaggregating the "disability" as "mental and physical disability" (in line with the SDGs emphasis on both). The Bill must recognize that people with disabilities do not only require curative and rehabilitative services, but health promotion and (secondary) prevention supports to enable optimal return to health and community participation. This is recognized in the SAHRC report on mental health services which notes the need for the NHI to consider the funding of community based services outside of the clinic setting as part of a holistic approach to promoting health and mental health. (pg. 22):

		"NHI includes mental health as part of the package of 'comprehensive health services'. The NDOH has targeted 2026 for the full implementation of the NHI scheme. … It is a concern that the 2017 National Health Insurance White Paper does not currently make allowance for community-based care of MHCUs. This appears to be inconsistent with the NHMPF, which refers to norms and standards for psychiatrists, psychologists, psychiatric nurses and allied professionals developed for community-based mental health care services". The report additionally recommends the following national actions: • NDOH should organize a meeting with all key stakeholders involved in mental health including Health, Social Development, Education, Housing, Corrections, Treasury and Labour to establish an interdepartmental standing committee on mental health that meets at least on a quarterly basis if not more frequently. • NDOH should appoint a permanent advisory body within the department whose role it is to monitor the observance of human rights in mental health service provision. • Establish a more comprehensive mental health information system. • Assess the public mental health system's ability to cater to the needs of children and adolescents with psychosocial disabilities: Such an assessment should detail the exact number of minors considered MHCUs and exact information to ensure that: children and adolescents with intellectual and psychosocial disabilities and mental conditions are no longer admitted to adult wards; and oversee systemic changes to current health infrastructure to guarantee the availability of community-based child and adolescent mental health services managed by stakeholders that include their caregivers, school and community.

		And in most provinces, "In consultation with the NDOH, develop a plan for the revitalization of forensic and non-forensic mental health infrastructure in the province which have been historically under-prioritized. Including details on budget and specific measures taken to realise a rights-based approach" It is recommended that the provisions of the Bill be updated to include consideration of the above. The recommended national advisory body should be consulted, or if not yet constituted permanently as recommended, the Minister should designate a committee to inform the NHI regarding mental health related components of the Bill as a matter of urgency, to be compliant with the SAHRC report.
General Issues Outside of Specific Chapters		
	Some practitioners provide mental health services in different geographical areas	How would this be dealt with under NHI? This needs to be carefully planned in order to hold to the original ethos of care for all.
	Gender binaries - wording	Within our diverse landscape, the wording of the document should recognize gender fluidity.
	Administrative support to manage the mandate	Massive administrative support will be required to manage the mandate of the NHI. This needs to be incorporated within the planning, as cutting corners at this stage of planning will have monstrous ramifications at implementation.
	Training bodies (registrars and interns)	It is unclear how NHI will co-operate with training institutions/universities where interns/registrars provide health care services across a range of settings from tertiary care to primary health care.
	Absence of deliberations around the cooperation with Traditional Healers and African centric knowledge systems. We know that the majority of rural care is performed by these groups.	The Bill does not recognize the need to co-operate with Traditional Healers and does not seem to consider African knowledge systems at all.
	Provincial health departments	The role of the Provincial DOH is unclear under NHI.

	Forensic mental health services	These consist of forensic mental health examinations in terms of sections 77 and 78 of the Criminal Procedure Act; assessments of children in conflict with the law in terms of section 11 of the Child Justice Act; survivor competency examinations; pre-sentencing assessments as well as forensic rehabilitation services of State Patients. These services require special provisions under NHI – particularly with regard to the provision of recovery based psychosocial rehabilitation to State Patients.

Conclusion

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

END OF DOCUMENT