

Strengthening the National Health Insurance Bill for mental health needs: response from the Psychological Society of South Africa

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Abstract

This article summarizes the findings of a consultation process initiated at the 25th congress of the Psychological Society of South Africa in September 2019 to submit a response to the national public participation process on the National Health Insurance Bill, 2019. While the Psychological Society of South Africa supports the overall purpose of the Bill, to provide universal health coverage in South Africa, this article critically discusses eight core concerns related to the Bill, including the need to: (1) integrate mental health more effectively into the National Health Insurance Bill; (2) ensure equitable access to health services for all people; (3) improve human resources for mental health; (4) clarify accreditation standards and contractual conditions for service providers; (5) improve utilization of private practitioners within an integrated health system; (6) include mental health expertise in the advisory structures of the National Health Insurance Bill; (7) set out a robust accountability framework within the National Health Insurance Bill; and (8) include mental health indicators in the National Health Insurance information system. Taken together, this article contributes to the ongoing deliberations about strengthening the National Health Insurance system to ensure that it is responsive to mental health care needs.

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Introduction

South Africa's health system is based on a Universal Health Coverage (UHC) approach. UHC commits to human rights-based access to quality promotive, preventive, curative, rehabilitative and palliative health care which does not burden users financially (World Health Organization, 2020). UHC requires a public financial management system which promotes sustainable financing (Cashin et al., 2017; Docrat et al., 2019). The National Health Insurance (NHI) Bill (Ministry of Health, 2019) sets out the mechanisms through which the South African government proposes to fund the reconfiguration of health care provision.

South Africa's health system needs reform to address inequities in access to health care arising from the enduring legacy of apartheid and systemic corruption post-1994 (Dassah, 2018). While the National Department of Health has initiated actions to address this (Pillay, 2019b), much remains to be done. The NHI Bill presents an opportunity to step up implementation of national policy commitments to improve service access, delivery and outcomes, including bringing parity to often overlooked mental health needs (Petersen et al., 2016).

South Africa has also committed to the United Nations (2015) Sustainable Development Goals (SDGs). Goal 3 of the 17 SDGs, Health and Wellbeing, underpins all goals and notes the centrality of mental well-being for overall health and related social determinants of health (Lund et al., 2018). Priority groups identified by the SDGs – women, children, the aged, poor people, and people with disabilities, inclusive of intellectual and psychosocial disabilities – are also priority groups for public health in South Africa.

Consultation process

Consultation was initiated at a roundtable discussion organized by the Psychological Society of South Africa's (PsySSA) Psychology in Public Service Division (PiPS) at the 25th PsySSA National Congress in September 2019. A committee (the authors) compiled an initial response which was circulated to PsySSA membership: 11 special interest divisions, 12 standing committees and provincial branches. Comments were reviewed and circulated for further deliberation by PsySSA membership and leadership. This is a second submission¹ to this legislative process following a submission on the NHI White Paper, dated 25 May 2016.²

Core considerations

PsySSA, as a representative body for psychology professionals in South Africa, supports the NHI Bill's focus on UHC as a social investment for a healthy and productive society, predicated on equity and social justice. In the following, we summarize eight core considerations which we noted for further attention in the NHI Bill in PsySSA's submission to Parliament in November 2019:

1. Integrate mental health more effectively into the NHI Bill.
2. Ensure equitable access to health services for all people.
3. Improve human resources for mental health.
4. Clarify accreditation standards and contractual conditions for service providers.
5. Improve utilization of private practitioners within an integrated health system.

6. Include mental health expertise in the advisory structures of the NHI Bill.
7. Set out a robust accountability framework within the NHI Bill.
8. Include mental health indicators in the NHI information system.

Integrate mental health more effectively into the NHI Bill

Programmes funded by the NHI Fund should include interventions which are responsive to four key areas described as follows:

- (a) *Provide adequate mental health services*: the National Mental Health Policy Framework and Strategic Plan 2013–2020 (Department of Health, 2013) acknowledges the importance of promoting psychological well-being and preventing ill-health and sets targets for prioritization of psychological services. However, access to meaningful psychiatric and psychological care and resilience-building interventions relevant to our context remains sub-optimal (Daniels, 2018). The South African Human Rights Commission (SAHRC, 2019) report on the National Hearings on the Status of Mental Health Care in South Africa (p. 2) 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 report provides direction for developing appropriate mental health services for people with psychosocial and intellectual disability within the current legislative and policy frameworks. The NHI Bill must enable acceleration of the implementation of the recommendations of the SAHRC report.
The NHI Bill must also clarify benefits and funding for non-clinic mental health services such as intermediate level care facilities and community services (SAHRC, 2019, p. 22). This is crucial following the Life Esidimeni tragedy in Gauteng and its lessons for deinstitutionalization (Moseneke, 2017; Freeman, 2018). Ongoing problems with licensing, monitoring, and capacity development of day care and residential community services for people with intellectual and psychosocial disabilities need urgent attention.
- (b) *Promote mental well-being within communities*: it is unclear how health promotion and illness prevention will be conceptualized under NHI. There is a lack of public awareness regarding mental health (Chippis et al., 2015) and ongoing stigma towards mental illness (Egbe et al., 2014). Psychology professionals must be actively involved in programme development and support services for primary care. For example, registered counsellors can contribute enormously to community-oriented provision of mental health promotion and prevention services (Rouillard et al., 2016) and should be more effectively utilized in the public health system, as originally conceptualized in the development of the profession.
- (c) *Embed mental health into physical health services*: people with mental health difficulties are less likely to live healthy lifestyles, negatively impacting on their physical health, and increasing their need for health services while physical ill-health can impact on mental well-being (Ohrnberger et al., 2017). People with psychosocial disability presenting with physical health problems may also not receive adequate physical health care as they are referred to mental health services due to diagnostic overshadowing.
- (d) *Address violence and trauma as a cross-cutting issue in service provision*: interventions subsidized by NHI must address the high levels of continuous traumatic stress that is a normalized feature of South African society (Kaminer et al., 2018). Poverty and constraints to social and economic development can erode psychological health and inhibit resilience needed to overcome these stressors (Swain et al., 2017). Continuous trauma experienced by citizens due to domestic and commercial theft, gender-based violence, murder, rape and other neighbourhood violence, and the mental strain due to state capture and increased economic vulnerability of our country requires inclusion of psychological interventions and skills to build a healthy, resilient socially cohesive national psyche (Eagle, 2015).

Ensure equitable access to health services for all people

In the following, we elaborate eight issues related to improving equitable access to mental health care:

- (a) *Ensure accurate assessment for access to care*: Section 7.4 of the Bill states that health care providers should refuse access to treatment where ‘(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 (benefits) formulary, except in circumstances where a complementary list has been approved by the Minister’ (Ministry of Health, 2019, p. 10). There is a risk that people may be turned away before an ‘adequate assessment’ has been conducted, as screening, diagnosing and treating mental illnesses are limited at primary health care levels, and task-sharing does not always yield positive outcomes (Lund et al., 2019; Padmanathan & De Silva, 2013). Health technology assessment tools will need scrutiny to ensure sensitivity and specificity to common and serious mental illnesses. Similar difficulties, for example, are currently being experienced by users with serious mental illness wanting to access social assistance where tools focus on physical health and are poorly designed to detect disabling mental health conditions.

Service users must have the right to a second opinion. In terms of the Patient Rights Charter (Department of Health, 1999), citizens 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’. Assertions in Section 7.5(b) and (d) of the NHI Bill (Ministry of Health, 2019, p. 10) that users will have ‘a reasonable opportunity to make representations in respect of such a refusal’ and a right to ‘adequate reasons for the decision to refuse the health care service to the user’ are not reassuring. The average citizen is unlikely to be in a position to make representation to the Fund, raising ethical and human rights concerns, and potentially increasing the existing barriers to health care (Schierenbeck et al., 2013). There is a dire need for meaningful participation by people in their own health care in line with the global ethic of ‘nothing about us without us’ (Ryan et al., 2019).

The determination of ‘cost effective mental health interventions’ to comply with Section 7.4(b) requires urgent attention from mental health professionals – as unlike other priority health programmes (e.g., TB, HIV, and eye care), robust local work has not yet translated into nationally accepted mental health interventions which can be accredited for implementation. Psychology professionals must be included in the development of mental health Diagnostic-Related Groups (DRGs) and in the determination of the Benefits Formulary to avoid a narrow biomedical approach as a benchmark for decisions.

- (b) *Ensure access is not denied through registration requirements for users*: Section 5(1) states that individuals ‘must register as a user with the Fund’ (Ministry of Health, 2019, p. 8) to be eligible for health services. The person must provide their biometrics and other information, including proof of habitual place of residence, an identity card, an original birth certificate or a refugee identity card. Many people do not have identity documents or the means to procure these. Provision must be made for temporary access to services until formal registration documents can be procured to avoid administrative injustice. Registration of users should also not be dependent on providing proof of habitual place of residence, due to homelessness, rapid urban migration, and expansion of informal settlements. Furthermore,

provisions must allow for citizens with a psychosocial, intellectual, or other disability which make it difficult to register independently to have a support person to assist with registration.

- (c) *Ensure timely access to care*: Section 6(f) notes that users should be able to ‘access health care services within a reasonable time period’. Time periods should be specified, given current long waiting periods at public facilities (A. L. Pillay, 2014). In the case of mental health emergencies such as suicidal or homicidal ideation or acute psychosis, access to health care interventions must enjoy priority.
- (d) *Prioritize children and adolescents in funding mental health services*: the SAHRC (2019) report makes special mention of children and adolescents, and this should be a prime focus of mental health service provision (Mokitimi et al., 2019). Early childhood development (ECD) centres, schools, and tertiary education institutions are important settings within which to introduce preventative and early intervention strategies that promote resilience and empowered citizenship in young people. Financing mechanisms must enable key partnerships through NHI, for example, with the Departments of Basic and Higher Education; Social Development; Justice, Health, Labour and Women, Youth and Persons with Disabilities to address the health needs of children, adolescents and young adults in crisis, in conflict with the law, out of school or exposed to abuse and maltreatment.
- (e) *Disaggregate psychosocial and intellectual disability from physical disability*: the Bill prioritizes people with disabilities. Given the tendency to focus on physical disability in service delivery, it is recommended that ‘disability’ be specifically disaggregated as physical, mental, intellectual and sensory disability throughout, in line with the United Nations Convention on the Rights of People with Disabilities (United Nations, 2006).
- (f) *Provide adequate services for refugees, asylum seekers and illegal foreigners*: Section 4(2)(a) and (b) of the Bill states that asylum seekers or illegal foreigners are only entitled to (a) emergency medical services and (b) services for notifiable conditions of public health concern. As a social justice and human rights-oriented organization, PsySSA cannot support any limitations on population coverage for health care. Many refugees, asylum seekers and illegal foreigners suffer from depression, anxiety and trauma, having left their home countries under duress, to live under severe economic hardship and fear in other countries (Schockaert et al., 2020). Providing only emergency medical services does not make sense – it is more cost-effective to treat a person with mild symptoms as an outpatient, than to wait for the condition to worsen, requiring specialized admission and longer, more intensive and costly treatment. It would also be unethical not to offer follow-up services after the initial emergency services. In its current form, the Bill risks perpetuating ‘medical xenophobia’ already experienced by refugees in South Africa (Zihindula et al., 2017, p. 13).
- (g) *Recognize gender fluidity and include the health needs of trans and gender-diverse individuals*: transgender and gender-diverse people struggle to access gender affirming health care due to stigma and other systemic barriers (Wilson et al., 2014). NHI must be based on the principle of affirmative health care as it relates to sexual and gender diversity, for lesbian, gay, bisexual, transgender, intersex, asexual, and queer people. Enabling people to live their authentic gender identity in society and to have access to affirmative health care, including the use of hormone replacement therapy and gender affirming surgery will improve mental health and lower suicide risk (Koch et al., 2019). PsySSA recently released affirmative practice guidelines for psychology professionals working in this field (McLachlan et al., 2019) and continues to advocate for a more gender-inclusive health care system.

- (h) *Improve access to forensic mental health services*: forensic mental health services require policy and service reconfiguration (Sukeri et al., 2016). These consist of forensic mental health examinations in terms of Sections 77 and 78 of the Criminal Procedure Act no. 51 of 1977 (Department of Justice, 1977), assessments of children in conflict with the law in terms of Section 11 of the Child Justice Act (Department of Justice, 2008), rape survivor competency examinations in terms of the Criminal Law (Sexual Offences and Related Matters) Amendment Act (Department of Justice, 2007), pre-sentencing assessments, and forensic rehabilitation services for state patients. These services require special provisions under NHI to enable recovery-based psychosocial rehabilitation of state patients (Kramers-Olen, 2014). The recommendations of the SAHRC (2019) report outline specific national and provincial actions required to improve forensic mental health care.

Improve human resources for mental health

The underfunding of mental health positions, including posts for psychologists and registered counsellors, requires attention to close the treatment gap in psychological services, even as government turns attention to curtailing excessive public service expenditure. Psychological and other mental health professionals should participate in formative discussions on human resource planning from the outset, especially for rural mental health posts (De Kock & Pillay, 2017). In terms of developing and promoting guidelines for norms and standards in Section 32(a) of the Bill, existing norms and standards for mental health (Lund & Flisher, 2006) need review to inform future staffing, budgeting and service provision.

Clarify accreditation standards and contractual conditions for service providers

Health service providers and health establishments will be accredited and contracted to provide specific service needs within their area of operation (Section 39), with reaccreditation and contract renewal dependent on proven achievement of prescribed performance criteria for service delivery. Clarity is needed on how standards will be set for contracting, monitoring and evaluating accredited health care service providers or establishments. Performance standards will also need to take into account specific scopes of practice. This must be done by an independent body, such as the Health Professions Council of South Africa (HPCSA) and/or the Office for Health Standards Compliance (OHSC). Accreditation should be overseen by health care practitioners from specific disciplines. The Bill also makes no mention of mechanisms to accredit and fund health services which cross district operational areas, such as tele-health services and services which operate across district-based areas.

Improve utilization of private practitioners within an integrated health system

The Bill provides for medical schemes to only fund complementary cover for services not reimbursable by the Fund (Section 33). However, for effective implementation, NHI needs to leverage the private sector as a strategy for sustainable financing (Docrat et al., 2019). The role of medical schemes needs clarity given that many health practitioners (including most psychologists) work in private practice and currently rely on medical schemes for their income. The NHI Bill must consider how its provisions will impact income-generation and employment opportunities in the private sector to curb fear and anxiety about future employment opportunities in South Africa, since practitioners who are not accredited will effectively be unable to work, as the fund will eventually cover most aspects of health care.

To prevent underutilization of well-trained health workers and unnecessary service gaps arising with the implementation of the new system, the Bill should enable utilization of the country's full complement of private and public service providers. District-based service licencing and contracts should be based on the best interests and needs of users, available from both public and private service resources within that area, rather than restricting private practitioners to complementary services only. In line with the Competition Commission (2019) recommendations for government to step up stewardship of the private health sector (Competition Commission of South Africa, 2019), care must be taken to set tariffs for the reimbursement of contracted private health establishments and providers at rates which will not unduly burden the limited resources of the health system.

Private practitioners include indigenous health practitioners, yet the Bill does not speak to African knowledge systems and their utilization (Kometsi et al., 2019). For example, there is no consideration of the role of traditional health practitioners as important stakeholders in (mental) health given that their services are culturally congruent with some citizens' worldviews (Campbell-Hall et al., 2010).

Include mental health expertise in the advisory structures of the NHI Bill

Mental health specialists, including psychologists, should serve on several relevant structures constituted by the NHI Bill. The Bill proposes several committees as follows: the Committees of Board (Section 23), the Benefits Advisory Committee (Section 25.2), the Health Care Benefits Pricing Committee (Section 26.2), the Stakeholder Advisory Committee (Section 27), the Disclosure of Interests Committee (Section 28), the Procedures and Remuneration Committee (Section 29), the Vacation of Office Committee (Section 30), the interim National Tertiary Health Services Committee (Section 57.3a), the interim National Governing Body on Training and Development Committee (Section 57.3b), the interim Ministerial Advisory Committee on Health Care Benefits (Section 57.3c), and the interim Ministerial Advisory Committee on Health Technology Assessment (Section 57.3d). While 'medicine' is listed as a member, other health professionals, including psychologists, are not represented. Medical practitioners cannot be expected to provide adequate input on decisions which impact other categories of specialized health, such as psychology. For example, specialized input from psychologists is needed in the Benefits Advisory Committee (Section 25) to ensure that health benefits include appropriate psychological assessments, interventions and equipment, while the Office of Health Products Procurement supporting the Benefits Advisory Committee will require expertise to include effective, quality child and adult psychometric tools for use in community, general, specialized, and forensic mental health service settings. All committees must strive to ensure *comprehensive* cover for all relevant psychotherapeutic and psychosocial treatments. Given that mental health programmes, benefits and equipment remain poorly integrated into the public health service (Burns, 2011), it would be advisable to convene a Mental Health Services Technical Committee, including a psychological services subcommittee of psychologists with practice and research experience.

Set out a robust accountability framework within the NHI Bill

There is a worrying centralization of power and decision-making and diminished service user autonomy in the Bill which, in its present form, holds significant risk for creating an unwieldy bureaucracy. Read against the backdrop of our current socio-political climate and the unfolding of the Judicial Commission of Inquiry into Allegations of State Capture, the success of NHI hinges on whether the public will trust government to be transparent and accountable. Even when citizens struggle to access health care, the majority are not willing to pay higher taxes for better health care

if they do not trust their government (Adisah-Atta, 2017). The potential for mismanagement of health funds is not unwarranted, given the poor financial situation of state-owned enterprises. Six issues of particular concern are outlined as follows:

- (a) The CEO must be a person of impeccable moral integrity, exceptional technical expertise in managing such a large Fund, with the requisite emotional intelligence to be a transformative leader. This will ensure greater public buy-in, confidence, and trust in the NHI system (Ward, 2017). This calls for stringent accountability mechanisms and criteria.
- (b) The Minister of Health will wield an inordinate amount of discretionary power over the health care system. Despite the checks and balances put in place to curb the abuse of power and 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 advisory committees and civil society more broadly can influence ministerial decisions. The role of the Provincial Departments is also unclear in the NHI Bill.
- (c) One coordinated purchasing and payment system for health care services will be unwieldy, risks being out of touch with particularities at local levels, and creates easy opportunity for corruption. The Office of Health Products Procurement (Section 38), for example, should include an oversight mechanism to prevent tender fraud and other criminal activities that plague government procurement processes.
- (d) The Bill proposes the establishment of a unit within the national office of the Fund to investigate complaints of fraud, corruption, other criminal activity, unethical business practices, and abuse relating to the Fund. Internal audit and forensic services within state-owned enterprises did not prevent the widespread depredation of public resources. The fund cannot investigate itself and must be subject to external scrutiny.
- (e) The provisions for the establishment of the Fund Board (Section 9), fund management, employees, and infrastructure are extensive and likely to utilize a substantial portion of the health budget intended for health services. There is a need to explicate mechanisms the Minister will use for expenditure control of the Fund.
- (f) The Bill makes no mention of an Ombudsperson to represent the interest of the public. The role of the Health Ombudsperson should be stipulated.

Include mental health indicators in the NHI information system

The National Health Information System (Section 34.1) must include comprehensive mental health indicators. Ultimately, the success of the aforementioned sections hinges on an accurate information system for the monitoring and evaluation of the implementation of the NHI system, both to address challenges in the initial roll out of the Fund and to inform strategic directions in its progressive expansion. Many public facilities still have limited technical infrastructure for information systems, without which accurate data management will be hampered. In addition, remote provision of scarce services via tele-health and interconnected health system communication, monitoring, and reporting, which relies on innovative technology in the Fourth Industrial Revolution era, must be considered within the NHI system.

The NHI and the COVID-19 pandemic

Since PsySSA's submission on the NHI, the impact of COVID-19 has highlighted anew inadequacies in UHC resourcing of health personnel, infrastructure, and equipment, forced greater intersectoral cooperation and mobilized resource reallocation to curb the pandemic. This response has led

to calls to fast-track the implementation of the NHI system, on one hand, and evoked concerns, on the other hand, that hasty implementation of NHI may further destabilize our fragile health system. Resource constraints have, for example, led to a de-escalation of attention to preventive services, early case detection, and health care for other key communicable and non-communicable health conditions as the country directs limited resources to the pandemic (<https://www.iol.co.za/the-star/news/patients-with-chronic-illnesses-left-in-the-cold-as-sa-focuses-on-covid-19-48476778>).

The particular vulnerability COVID-19 presents for the health and well-being of people with psychosocial and intellectual disability also calls for a disability-inclusive response to the pandemic (United Nations, 2020) which is not well articulated within NHI provisions. The pandemic highlights the links between health and well-being and other SDGs such as poverty, hunger, nutritional security and agricultural sustainability, the social and health value of education, and the health implications of poor access to safe water, sanitation, energy, housing and sustainable production. The mental health impact of health disparities has been exacerbated during the pandemic, resulting in immense psychological distress for individuals, communities, and health workers (Dubey et al., 2020). Responses to the psychological impact of the pandemic must prioritize a range of psychological interventions to address mental health concerns and stressors induced by fears of contracting COVID-19, loss of life, economic losses, and other anxieties (Pfefferbaum & North, 2020).

The lens of our current experiences during the pandemic clarifies the relevance of recommendations made above to ensure adequate funding for and integration of mental health services into primary health services, the link between systemic inequalities and (mental) health status of communities, and the need for widely accessible psychosocial interventions. We have been challenged to innovate in response to the need to increase access to psychological services under the novel pandemic conditions, innovations which could inform cost-effective interventions under NHI. One area which warrants attention, for example, is investment and development of contextually and economically appropriate tele-health interventions (Chifamba, 2018).

Conclusion

South Africans seek improvements in the quality of public health services and want the effective reconfiguration of health care via NHI to be a top priority for government (Booyesen & Hongoro, 2018). However, key stakeholders continue to express concern about the feasibility of NHI to address and close the (mental) health treatment gap (Stanton, 2017). Yogan Pillay (2019a), former deputy director general of communicable and non-communicable diseases in the department of health, wrote,

Under National Health Insurance we must clearly define the package of mental health services that will be provided at each level of care, ensure that there are mental health professionals able to provide this package and that this package is fully funded. Given the increasing burden of diseases attributed to mental disorders the work to strengthen preventive, treatment and rehabilitative services are critical. All available resources must be utilised in creative ways to meet these needs.

These sentiments are cause for optimism, and we hope that the core considerations outlined in our submission add to ongoing discussions about how best to offer equitable, quality mental health care in South Africa. Finally, we urge government to take seriously all submissions and commentary on the NHI Bill. Researching the public consultation process leading up to the development of the national mental health policy in 2013, for example, Marais et al. (2020) found that no substantive changes were made to the policy following numerous consultation summits, and that there were no systematic processes for facilitating and capturing knowledge inputs. We discovered in

early March 2020 that our November 2019 submission was not officially captured, requiring a substantial back-and-forth process to rectify this, with assurances that this omission was administrative and not a substantive exclusion of our comments. Psychology professionals must be vigilant to maintain their participation and relevance in public policy processes which ultimately impacts on the delivery of psychologically sound, quality public mental health service delivery.

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Notes

1. Available at <https://www.psyssa.com/wp-content/uploads/2019/11/PsySSA-Response-to-the-NHI-Bill-211120191.pdf>
2. Available at <https://www.psyssa.com/wp-content/uploads/2016/05/PsySSA-Response-to-the-NHI.pdf>

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