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27 November 2019

Chair: Portfolio Committee on Health
Dr Sibongiseni Dhlomo

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

Dear Dr Dhlomo and Portfolio Committee on Health

National Health Insurance Bill, 2019
Comment by the National Mental Health Alliance Partnership

The National Mental Health Alliance Partnership (NMHAP) thanks the Chair of the Portfolio Committee on Health for the opportunity to comment on the National Health Insurance Bill (B 11-2019). This comment pertains to one critical area of mental healthcare services: access to multidisciplinary care appropriate to the severity of the mental health condition. As an Alliance Partnership, we fully endorse the submissions of each participating partner. Please read the partners' submissions for our recommendations on the Bill as a whole.

Mental, intellectual, or psychosocial disability impinges on accessibility of physical and mental health care. Poor access to care for people with such disabilities affects their mental and physical health outcomes. Mental illness tends to have its onset in youth and persist throughout life in a chronic, frequently unstable, manner. It requires regular and consistent intervention to ensure quality of life and optimised functioning for the individual, as well as to prevent rehospitalisation, increasing disability, worsened physical health outcomes (including maternal and child health, non-communicable diseases, HIV, TB). People with intellectual disability are extremely vulnerable to neglect and are likely to have physical and mental health conditions which remain untreated because of poor access to care.

The district health system thus needs capacity to serve community dwelling people with severe mental intellectual and/ or psychosocial disabilities, including those living in NGO residential homes. For care, treatment, and rehabilitation to be effective, a complex human resource mix is needed to harness the user's own support system and achieve successful health outcomes. However, the NHI Bill restricts district health to 'primary health care', which is often interpreted in a narrow, inflexible manner. This does not allow for accessible, community-based, specialist level mental health care, this being beyond the scope of practice of PHC practitioners, leading to people being lost to follow up as they are simply up-referred to hospitals.

We believe a District Health Management Office needs to coordinate the provision of mental health professionals (including occupational therapists, psychologists, social workers, psychiatrists and psychiatrically trained medical officers) in addition to PHC. Such teams would deliver ambulatory services in the PHC setting to people with complex mental health conditions and support PHC practitioners in the care of those with less complicated conditions. In this way, accessible, integrated and collaborative mental health care may be realised.

While we appreciate that the stipulation of such community-based specialist services as a universal necessity may create unrealistic expectations of district staffing, we believe regional variations and future progress must be accommodated. Thus, we recommend that the clauses pertaining to district health services should be phrased in a manner as to allow flexibility in the human resource mix, enabling the DHMOs to respond to population health needs.

This would allow community mental health services to develop incrementally. It would also allow development of other Community Specialists, e.g. community paediatrician or community obstetrician/ gynaecologist, as indicated by needs and availability of specialists.

In this regard, we comment on three clauses:

- Chapter 11 - Clause 58 Repeal and Amendment of Legislation Affected

  National Health Act 2003, point 6, insertion of District Health Management Offices in Section 31A(3)(f). We are delighted to observe that the coordination of district specialist support teams has been included as a function of the District Health Management Offices.

- Chapter 8 – Clause 36 Role of the District Health Management Offices

  To be consistent with Clause 58 of Chapter 11, to allow for flexibility in addressing the health needs of a district population in a preventative manner that optimises individual function and well-being, and to be aligned to the Mental Health Care Act No.17 of 2002, we suggest the phrasing of this clause is amended as follows:

  From: A District Health Management Office established as a national government component in terms of section 31A of the National Health Act must manage, facilitate, support and coordinate the provision of **primary health care services** for personal health care services ….

  To: A District Health Management Office established as a national government component in terms of section 31A of the National Health Act must manage, facilitate, support and coordinate the provision of **ambulatory healthcare in the district setting** for personal health care services ….

  Or: ….. the provision of **district healthcare** for personal …

- Chapter 8 – Clause 37 Contracting Unit for Primary Health Care

  To align with Clause 58 and the proposed change to Clause 36, we suggest that Clause 37 allows for the payment of mental health professionals, including specialists and allied healthcare workers, at district level on a performance base.

  We suggest the following changes to clause 37:

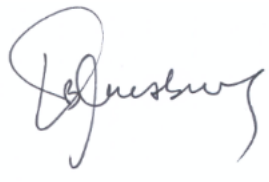
  A change to the title and to 37(1), From: Contracting Unit for **Primary** Health Care
  To: Contracting Unit for **District** Health Care

  Change of 37(1)(a), From: … manages the provision of **primary** health care services, such as ….

To: …. manages the provision of **district** health care services, such as

Insertion to the clause:
37(1)(c) facilitates payment of district specialists and allied health professionals, according to the requirements of 41(3)(b)

Thank you very much, with best regards



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For SAMHAP

Prof Bernard Janse van Rensburg

Co-Chair SA NMHAP (082 807 8103)