SUBMISSIONS TO THE PORTFOLIO COMMITTEE ON HEALTH IN RESPECT OF THE NATIONAL HEALTH INSURANCE BILL [B11-2019]

Submitted by
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INTRODUCTION

1. We refer to the call for comment opened on 30 August 2019 in respect of the National Health Insurance Bill [B11-2019] ('**the Bill**'). We welcome the opportunity to make these submissions and to engage with the issues related to the Bill. **We also take this opportunity to note that we will avail ourselves to make oral representation on the submissions made herein should we be called upon to do so.**

2. As stated in the 'Memorandum on the objects of the National Health Insurance Bill, 2019' ('**Memorandum**') the creation of the National Health Insurance Fund is a strategy for moving towards Universal Health Coverage[1] of which one of the aims is to provide South Africans with access to needed health care that is of sufficient quality to be effective.[2]

3. The proposed section 57(2)(a) seeks to provide that, in implementing the Act in terms of a two-phase process, Phase 1 must include '*the purchasing of personal health care services for vulnerable groups such as children, women, people with disabilities and the elderly*'[3] and it must '*continue with the implementation of health system strengthening initiatives*'.[4]

4. The Preamble of the Bill recognises the Constitutional rights to bodily and psychological integrity, which includes the right to make decisions concerning reproduction; and to have access to health care services, including reproductive health care.[5] The proposed definition for 'health care service' in section 1 includes reproductive health care.

5. In terms of section 35, the Fund '*must actively and strategically purchase health care services on behalf of users in accordance with need*' [own emphasis].[6]

6. The Memorandum lists that some of the barriers to access to affordable, quality health care services are: distance to health facilities, which includes such in terms of availability and cost of public and emergency transport; the lack of sufficient and qualified staff in the public health sector and in relation to the size of the population served by this sector; and the misdistribution of health care providers between geographic areas, with a high concentration in urban areas.

[1] Memorandum on the objects of the National Health Insurance Bill, 2019 at 1.1.
[2] Ibid at 1.2(a).
[3] Section 57(2)(a)(iv) of the National Health Insurance Bill.
[4] Section 57(2)(a)(i) of the Bill.
[5] Constitution of the Republic of South Africa, sections 12(2)(a), and 27(1)(a).
[6] Section 35(1) of the Bill.

7. These submissions go to the ‘quality’ of, ‘access’ to, and definition of ‘health care services’ which the Fund seeks to provide to its users, especially as they relate to women.

8. It is our submission that the current healthcare system, more broadly and specifically as it relates to the provision of sexual and reproductive health care and services, is too weak or fractured to work in tandem with the proposed NHI Fund; and if it were to pass, that the Bill must make provision for the adequate purchasing of sexual and reproductive health care and services to women in South Africa. Our submission is therefore two-fold, arguing two central points, that:

    8.1. The current health care system does not support women, especially as it relates to the provision of sexual and reproductive health care and services. We recognise that the provision of these services, within a sexual and reproductive justice framework, are necessary for the attainment and enjoyment of substantive equality for women in South Africa, and more especially for poor, black women living in under-resourced parts of the country. The Act and its provisions, irrespective of the formulation, cannot work in the current health care system, which fails women; and

    8.2. If the Bill is to continue along the parliamentary process, then we submit that it needs to make express provision for the procurement of adequate and comprehensive sexual and reproductive health care and services for women, and particularly the most vulnerable and under-resourced.

9. Our submission is therefore gendered in nature, and will deal with the following in arguing the two central points:

    9.1. The status of the current public healthcare system in South Africa and its inability to provide adequate access to comprehensive sexual and reproductive healthcare and services for women;

    9.2. The public/private divide, and the unequal distribution of health care services and resources in South Africa;

9.3. The effect of unequal distribution on women's access to quality sexual and reproductive health and services; and

9.4. Specific submissions relating to provisions of the Bill.

THE AUTHORS

10. The **Women's Legal Centre** ("The Centre") is an African feminist legal centre that advances women's rights and equality through strategic litigation, advocacy and education and training. We aim to develop feminist jurisprudence that recognises and advances women's rights. The Centre drives a feminist agenda that appreciates the impact that discrimination has on women within their different classes, race, ethnicity, sexual orientation, gender identity and disability. The Centre does its work across five programmatic areas including the right to be free from violence, women's rights in relationships, women's rights to land, housing property and tenure security, women's sexual and reproductive health rights and women's rights to work and conditions of work.

11. The **Legal Resources Centre ('LRC')** is a public interest, non-profit law clinic in South Africa that was founded in 1979. The LRC uses the law as an instrument of justice to facilitate the ability of vulnerable and marginalised persons and communities to assert and develop their rights; promote gender and racial equality and oppose all forms of unfair discrimination; as well as contribute to the development of human rights jurisprudence and to the social and economic transformation of society. The LRC operates throughout South Africa with offices situated in Johannesburg, Cape Town, Durban and Grahamstown. Through strategic litigation, advocacy, and education and training, the LRC has played a pivotal role in developing a robust jurisprudence in the promotion and protection of equality and non-discrimination, and other constitutional rights. A significant proportion of the LRC's work has been in the sphere of gender equality, non-discrimination and addressing the disproportionate burden faced by women as a result of poor service delivery. Within the arena of equality and non-discrimination, the LRC has viewed the rights of vulnerable and marginalised persons, including refugees, children and women, as being integral to the advancement of society and achieving equality and justice for all.

12. The **Sexual and Reproductive Justice Coalition** is a South African coalition working towards an intersectional lens on reproductive justice. The SRJC aims to provide a platform through which individuals and organisations produce and use evidence to foster informed public debate and consensus building, working towards holding policymakers and implementers accountable for progress towards realising sexual and reproductive justice for all. Through its work, SRJC hopes for a future of sexual and reproductive justice informed by an intersectional perspective in which all people, irrespective of class, race, gender, sexual orientation, gender expression, disability, age, religion or any other factor, can enjoy their sexuality, make reproductive decisions and access high-quality services in ways that enhance their dignity, bodily integrity and wellbeing.

FAILING WOMEN: THE STATE OF HEALTH CARE SERVICES IN SOUTH AFRICA

a) *Inequality in access*

13. The right to health care is enshrined in the Constitution, and, as stated above, includes the right to reproductive health care. As one of its goals, the Bill seeks to ensure that the entire population is entitled to benefit from necessary, high quality health care, and that it is no longer to be enjoyed by certain groups only.[7] The legacy of apartheid saw that the health system was and remains split along racial lines. The healthcare system continues to benefit the white minority population, whilst remaining severely under-resourced and inaccessible to the black majority. It continues to perpetuate the systemic inequalities designed and implemented by a racist regime.

14. It is common cause that the majority of South Africans from low-income and poor households rely on public health facilities to meet their health care needs. Approximately 83% of the South African population rely on the public healthcare system, of which the majority are women, making up 51% of the total population.[8] Woman experience higher levels of poverty than their male counterparts, with a headcount of 58.6% in comparison to men at 54.9%.[9]

15. In using distance to the nearest hospital as an indicator, a recent joint study by the Department of Planning, Monitoring and Evaluation, Statistics South Africa, and the

[7] Memorandum on the objects of the National Health Insurance Bill, 2019 at 5.2(a).
[8] Department of Statistics South Africa, available at http://www.statssa.gov.za/?page_id=593 (accessed on 28 November 2019)
[9] Statistics South Africa, 'Poverty' available at http://www.statssa.gov.za/?page_id=739&id=1 (accessed on 28 November 2019).

World Bank showed that the poorest in South Africa (33.8% decile) lived at least 20 kilometres away from a hospital, which was 27 percentage points higher than the proportion of the richest decile.[10] Even more, rural communities (where poverty is consistently higher among persons living in these areas),[11] are only served by 12% of the country's registered doctors, and 19% of its registered nurses.[12]

16. Within this inequality in access to resources along poverty lines is a racial and gender divide, leaving poor, black women in South Africa in the worst position when accessing healthcare services; and the quality of these services are severely stunted, with only 5 out of 649 public health facilities across South Africa complying with the norms and standards set by the Department of Health.[13] This is further aggravated by the statistic that 16.9% of the population is registered with a medical aid scheme in South Africa, allowing this limited number of people to have access to private medical care.[14]

17. It follows that the experience of access to sexual and reproductive health and services necessarily tracks the same disproportionate pattern of unequal distribution in general health care services and resources. The public healthcare system is in such a skewed state, unable to provide the majority of the population with adequate access to quality health care services, which health care services necessarily include access to sexual and reproductive health care. These services are used by the majority of the population – women. It is imperative for the legislature to ensure that women are no longer neglected when formulating laws and policy.

18. The current dire state of health care in South Africa necessitates the need to reform health service delivery. The state has an obligation to provide women who approach a public healthcare facility with positive experiences and quality health care and services.

b) *International and regional law obligations to improve access to quality healthcare*

19. The right to health care is not only guaranteed in the Constitution but is also a well-established right in international law. Section 27 of the Constitution provides for the right to health care for *everyone*, which explicitly includes access to reproductive health care. Section 12(2) of the Constitution confirms that everyone has the right to bodily and

[10] 'Overcoming Poverty and Inequality in South Africa: An Assessment of Drivers, Constraints and Opportunities' (March 2018) prepared by the Department of Planning, Monitoring and Evaluation, Statistics South Africa, and the World Bank, p 23.
[11] Ibid, p xix.
[12] 'Human resources for health South Africa: Strategy for the health sector (2011)'.
[13] https://www.news24.com/SouthAfrica/News/the-dire-state-of-healthcare-20180610-2
[14] Statistics South Africa, 'Statistical Release P0318 – General household survey' (2017), p 23.

psychological integrity, which includes the right to make decisions concerning reproduction and to control over their body.

20. The International Covenant on Economic, Social and Cultural Rights ("**ICESCR**") provides for the right to health in article 12 by enjoining states to recognise the right of everyone to the enjoyment of the highest attainable standard of physical and mental health. The Committee on Economic, Social and Cultural rights ("**CESCR**"), in its General Comment No. 14, has elaborated on the normative content of the right to health by recognising the right to health to include equal access for all, on the principle of non-discrimination, to health care facilities, goods and services. It also requires states to implement measures to '*improve child and maternal health, sexual and reproductive health services, including access to family planning, pre- and post-natal care, emergency obstetric services and access to information, as well as to resources necessary to act on that information."*[15]

21. CESCR General Comment 22 on the right to sexual and reproductive health, in terms of article 12 of the ICESCR, further recommends that states are to adopt legal and policy measures to guarantee access to affordable, safe and effective contraceptives, comprehensive sexuality education, guarantee women and girls access to safe and legal abortion services, and to respect women's right to make decisions about their sexual and reproductive health. These measures are required in preventing unintended pregnancies and unsafe abortions.

22. Article 12 of the Convention on the Elimination of all forms of Discrimination against Women ("**CEDAW**") encourages states to take appropriate measures to eliminate discrimination against women in the field of health care. It recognises the importance of women's right to health during pregnancy and childbirth as it is closely linked to their right to life.[16] Additionally, states are compelled to ensure women-specific services are available in connection with pregnancy, confinement and the post-natal period, granting free services where necessary, as well as adequate nutrition during pregnancy and lactation.

23. On a regional front, Article 14(1) of The Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa provides that state parties shall ensure

[15] Committee on Economic and Social Cultural Rights, General Comment 14, at 14.
[16] CEDAW General Recommendation 24: Women and Health, at 2.

that the right to health of women, including sexual and reproductive health, is respected and promoted.

24. All the above clearly establish that the state has an obligation to act and improve the experiences of women in childbirth, including guaranteeing the right to equality, dignity, health care, and bodily autonomy, among others. Section 7(1) of the Constitution is clear in its statement that the state must respect, protect, promote and fulfil the rights in the Bill of Rights, with the state including the Legislature. We will now discuss what this obligation means.

c) *Conclusion*

25. We argue that all available resources and time should first be spent on fixing the public health care system to improve the experiences of those accessing such services before legislative advancements are considered. We believe that this approach puts women first and seeks to ensure their access to quality health care and services.

26. As a result, it is necessary to improve the public healthcare system <u>prior to</u> enacting the NHI Bill and seeking to implement it. The challenges of inequality are exacerbated by the existing, weak healthcare system, and the NHI Bill cannot function in an unsustainable system that is incapable of adequately caring for the majority of the population.

27. Furthermore, those sections that speak to the objective of strengthening the healthcare system and putting measures in place are inadequate in ensuring follow through, leaving a great deal of responsibility at the discretion of the Minister of Health to pass effective regulations to ensure such systems are in place to strengthen the current healthcare system. It is submitted that in its current formulation, this plan of action or avenue of redress is weak in setting out clear parameters within which the Fund will work with and alongside the current provincial departments of health, the Ministry, statutory bodies, and Parliament to ensure the proper improvement of the public healthcare system. Even more, to do this adequately would require concerted efforts on the part of the state, to the exclusion of the implementation of the NHI, given the dire state of the public healthcare system. Consequently, we submit that the NHI cannot proceed, as it will not succeed, in the current public healthcare system.

THE PUBLIC/PRIVATE DIVIDE IN ACCESS TO QUALITY SEXUAL AND REPRODUCTIVE HEALTHCARE SERVICES AND RESOURCES

28. The following table illustrates the imbalances of sexual and reproductive health care and services made available to women in the public health care sector versus the private health care sector.

	PUBLIC	**PRIVATE**
Abortion services	National Abortion Clinical Guidelines still to be approved by Health Professions Council. Only 7% of total public health facilities offer services. 10% of maternal deaths occur from unsafe abortion. National Department of Health has not led the process of procuring generic abortion drugs. Experiences of stigma and refusal of services on the basis of unregulated and unmonitored conscience claims by service providers and health facility staff.	Medical abortion widely available. Surgical abortion not widely available. Limited services available in second trimester due to poor continuous medical education.
Contraception	Limited options available and increased stock-outs. Most women given injectable contraceptives. Limited range of oral contraceptives, IUCD, female condoms and implants available. Post exposure prophylaxis and emergency contraception not widely available.	Not viewed as a prescribed minimum benefit. Post exposure prophylaxis and emergency contraception available. Not covered by medical aids but household insurances provide options of coverage.
Cervical cancer screening and treatment	Not widely implemented; limited recourse to	Women who are screened tend to be over-serviced.

	treatment for those with positive pap smears.	
Cervical Cancer HPV vaccination	In SA, two vaccines - Gardasil and Cervarix are currently registered for the prevention of HPV-related disease. The NDOH has made provision for Cervarix from 2014 for Grade 9 girls in public sector schools and reached 80% coverage.	Both available but not covered by medical aids.
Integration of HIV/AIDS services into fertility planning	Policy and clinical guidelines on integration are in place, yet poor implementation. Instances of forced abortion, denied abortion, forced contraception and sterilization.	Services available
Mental health services	Poor coverage of services and referral. Frozen posts of social workers and psychologists.	Services available yet costly; coverage uneven and remains unaffordable for many.
Gender affirming care	Poorly trained health providers in relation to diverse sexual orientations and gender identities. Uneven supply of hormones. Long waiting lists of gender affirming surgeries.	Services available yet costly and unaffordable for many. Medical aids provide uneven care and regulation is discriminatory.

29. According to a report compiled by Amnesty International, it was found that the private health care sector employs the majority of health care professionals and spends nearly 6 times more per patient in comparison to the public health care sector.[17] This disproportionate access in care and services applies to the provisions of sexual and

[17] Amnesty International, 'Briefing: Barriers to safe and legal abortion in South Africa' (2017), p 12.

reproductive health care and services to women who rely on the public health care system.

30. As stated before, this divide in access intersects across gender, race, and economic lines.

31. Should the NHI be passed, we submit that there is a high probability that more services will be procured from the private health care sector versus from the public health care sector given the disparities in the quality of, and access to, care. The proposed 'strengthening' of the public health system, as proposed by the NHI Bill, may occur; however, we submit that an over-reliance on access to private health care providers and establishments will be created. Access to private health care providers and establishments will be set at higher rates than access to the public health sector, and the former's resources (both human and medical) will not be able to sustain servicing the 83% of the South African population who historically relied on the public health care system.

32. Consequently, the current operation of the healthcare system in South Africa along public and private lines, and the weak state of the public healthcare system, cannot support the effective implementation of the proposed NHI. It is necessary to first close the gaps in access and service provision that exist between the private and public health sectors, and to strengthen and maintain a quality public health system before the NHI, in pursuit of Universal Health Coverage, can be pursued in South Africa.

THE EFFECT OF UNEQUAL ACCESS ON WOMEN'S ACCESS TO COMPREHENSIVE AND QUALITY SEXUAL AND REPRODUCTIVE HEALTH AND SERVICES

33. Access to sexual and reproductive health care and services is more proportionally a woman-specific experience given the types and assortment of health care services women rely on in this respect.

34. As a result of the direct link between gender, poverty and racial discrimination from apartheid, indigent women continue to be marginalised in their ability to access basic services, such as healthcare. The Constitutional Court in South Africa is committed to the transformative values of the Constitution and has reiterated the importance of providing adequate services to marginalised, vulnerable persons, as illustrated in the matter of *The Government of the Republic of South Africa and others v Grootboom and*

others[18]. The Court confirmed that rights entrenched in the Bill of Rights cannot only be understood in their textual setting, but rights must be understood in their social and historical context.[19]

35. Furthermore, rights are not experienced in isolation, but operate in conjunction with and are intimately connected to one another. The right to health care in South Africa, and therefore when trying to access health care, implicates the rights to equality (section 9); dignity (section 10); privacy (section 14); and freedom and security of the person (section 12). Where the healthcare system fails women, it also infringes on the enjoyment of these constitutionally enshrined and protected rights.

36. As already mentioned, health care services in South Africa have historically been skewed in terms of race, gender and socio-economic status. The institutional mechanisms established to deliver health care services have historically reflected and continue to reflect a disproportionate bias in favour of dominant groupings in society, with services to women continuing to lag behind other services.[20]

37. With respect to women's experiences of health care and services during childbirth, these services continue to be divided along racial lines. Black and coloured women give birth primarily in public facilities and white women giving birth with specialist physicians in private hospitals.[21] The experiences of women in public health facilities indicates poor, unequal, and inefficient medical care, which often give rise to medical negligence claims.[22] Chadwick et al[23] highlighted that women accessing maternal health care services at public health facilities attested to negative interpersonal relations with caregivers; lack of information; neglect and abandonment; and the denial of the presence of a labour companion during birth.

38. Abortion service provision in the public health sector is riddled with obstacles for women trying to access this service. These include:

[18][2000] ZACC 19.
[19] Paragraph 22.
[20] K Moyo "Realising the right to health in South Africa" (2016) Foundation for Human Rights page 5.
[21] M Hasting-Tolma, A Tolte & A Temane "Birth Stories From South Africa: Voices Unheard" (2018) *Women and Birth* 31 p43.
[22] Examples of medical negligence cases include: *Hoffman v Member of the Executive Council Department of Health, Eastern Cape* 2011 JDR 1081 (ECP)*; Mbhele v MEC for Health* (355/15) [2016] ZASCA 166*; Makgomarela v Premier of Gauteng and another* [2012] ZAGPJHC 217*; Sifumba v Member of the Executive Council for Health Eastern Cape* 2015 JDR 1597 (ECM); *Nzimande v Member of the Executive Council for Health, Gauteng* 2015 (6) SA 192 (GP).
[23] R Chadwick, D Cooper & J Harris "Narratives of distress about birth in South African public maternity settings: A qualitative study" (2014) 30 *Midwifery*.

38.1. Stigma and discrimination. This is often expressed through health facilities and providers refusing services on the grounds of religious beliefs and conscience, turning women away when they seek an abortion, and often without referring them to a health care provider who is willing to provide them with the service.

38.2. Restricted access to doctors authorised to provide terminations;

38.3. A limited number of health care facilities at which women can access abortion services. Of the 505 facilities designed to offer abortion services in South Africa, only 264 are providing access to first and second trimester abortion services.;[24]

38.4. Poorly trained, or untrained, staff employed at these limited health care facilities are unable to provide women access to abortion services in a manner that is respectful and sensitive to their medical needs.

39. It is estimated that 50% of abortions are procured in the informal sector as women turn to unsafe and illegal abortion services for assistance where the public health system has failed them.

40. The continued violation of women's bodies perpetuates and reifies their marginalised positions in society. Through lack of access to quality and comprehensive health care services, and more so gender-specific sexual and reproductive health care and services, women and their needs continue to be invisibilised or blatantly ignored when key steps are taken to budget and plan for their empowerment, equality and affirmation of their place in society.

41. We submit that it is necessary to ensure that the public healthcare system, upon which the majority of women rely, is strengthened so that women may have access to quality health care and services, which is necessarily an avenue towards gender equity in South Africa.

SPECIFIC SUBMISSIONS IN RESEPCT OF THE BILL

42. It is submitted that should the Bill continue along the legislative process, that certain amendments are made to ensure that women's access to comprehensive and quality sexual and reproductive health and services be a priority within the structure of the NHI. It is therefore necessary to embed this ethos in the language of the Bill, ensuring a

[24] Amnesty International, 'Briefing: Barriers to safe and legal abortion in South Africa' (2017), p 8.

committed legislative dedication to improving women's access to quality health care, which includes within its bouquet access to quality sexual and reproductive health and services.

a) *Section 1*

43. "comprehensive health care services" – in its current iteration, though it refers to a range of objectives the services are to ensure, the definition does not provide a list of necessary services to be provided that would serve as a basic make-up of comprehensive health care services. We submit that this section requires a more robust definition to ensure the public is aware of those services to which they would be entitled, and for which the Fund would strive to attain when procuring services on behalf of the public.

44. We further submit that the definition includes:

"sexual and reproductive health care services, which includes, but is not limited to:-

a) access to safe and legal medical and surgical abortion services;
b) access to quality pre- and post-abortion care;
c) access to a wide range of modern contraceptive methods, including IUCDs, rings, patches oral contraceptives, female condoms, and implants;
d) information regarding different contraceptive methods;
e) access to obstetric services free from violence, stigma, discrimination and coercive practices;
f) HPV vaccination and cervical cancer screening and treatment;
g) access to vaccinations and treatment for sexually transmitted diseases;
h) integration of HIV/AIDS services into fertility planning, which services are free from violence, stigma, discrimination and coercive practices;
i) mental health services;
j) Post Exposure Prophylaxis (contraception and ARVs) and forensic care including sensitive and effective collection of evidence following sexual assault; and
k) gender affirming care"

45. The definition of "health care service" includes "reproductive health care", the meaning of which must correspond with the expanded definition provided above. It would be necessary to insert a reference to the definition as provided for in the definition of "comprehensive health care services". This ensures that where either term is used

throughout the Act that it includes an express mention of sexual and reproductive health care and services, and that those services and benefits to be procured will always include those listed in the definition.

b) *Section 42: Complaints*

46. The section provides for a complaint's procedure for an affected person to lodge a complaint with the Fund, of which a user is considered an affected person for the purposes of the section. The process involves lodging a complaint; an investigation occurring; recommendations as to the resolution of the matter; the complainant is informed of the outcome of the investigation and any decision taken by the Fund; and opportunity to make representations.

47. Unfortunately, the opportunity to make representations, and the process that follows it, in terms of section 42(4) has been limited to health care service providers, and therefore excludes users. It is submitted that the section must not limit those persons who may make representations to 'health care service providers' only. Instead, the term should be replaced with 'an affected party' so that complainants of any nature, including those persons who are the subject of the complaint, and affected third parties may rely on the section to make representations to the Fund; have the representations considered by the Fund; and be provided with adequate reason for the Fund's decision.

48. Furthermore, the section should not exclusively limit this process to instances where the Fund makes a decision '*to withdraw or refuse the renewal of accreditation to the health care service provider*'. Instead, the mechanism should be available to all decisions taken by the Fund in terms of complaints lodged with it so that affected parties to a complaint may have extensive access to internal remedies. Extending the section's application makes practical sense when read together with section 43, 'Lodging of appeals'.

CONCLUSION

49. The National Health Insurance Bill should not pass. We submit that it is incapable of achieving its objectives, and therefore the achievement of equitable access to comprehensive and quality health care services, especially as they relate to women, due to the current dire state of the public health system in South Africa. The public healthcare system is a necessary component to the success of the NHI, as approximately 83% of the population relies on it, and with only 16.9% of the population registered with a

medical aid scheme to cover access to private health facilities, it is necessary to strengthen the public healthcare system to ensure that it can support the NHI before the latter is introduced.

50. We trust that you will find this submission made by the WLC, LRC and SRJC useful. Should you have any comments or questions please do not hesitate to contact Ms Solomons at nasreen@wlce.co.za; Ms Mudarikwa at mandy@lrc.org.za or Ms Stevens at marion@srjc.org.za.

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