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"WOMEN MARCHING FOR EQUALITY DEVELOPMENT AND PEACE"

PROGRESSIVE WOMEN'S MOVEMENT OF SOUTH AFRICA

NHI BILL Inputs

WOMEN AND IN PARTICULAR URBAN AND RURAL WORKING-CLASS WOMEN NEED THE NHI AND UNIVERSAL ACCESS TO HEALTH CARE

1. INTRODUCTION

1.1. Women in South Africa are impacted on by the disease burden and by the resourcing and practices of the South African health care system in a number of ways, due to:

- 1.1.1. women's particular vulnerability to **communicable diseases**;
- 1.1.2. women's particular susceptibility to **non-communicable diseases** shaped by their socio-economic and patriarchal responsibilities;
- 1.1.3. women's **unique reproductive life cycle**;
- 1.1.4. women's vulnerability to **gender-based violence** and its prevalence in South Africa;
- 1.1.5. women's **role in caring for the ill and disabled members** of their families and communities.
- 1.1.6. the **ongoing patriarchal attitudes and practices of the medical profession** in South Africa remains bedevilled by patriarchal attitudes and practices that make equality for women medical doctors, specialists and nurses a yet to be achieved goal.
- 1.1.7. the impact on the **ability of women employed in the profession to all function as their profession requires** of the uneven resourcing (infrastructure, equipment, medicines, finances, transport, ICT and human resources) of the South African healthcare system;
- 1.1.8. the **impact on women's patient rights** of uneven resourcing (infrastructure, equipment, medicines, finances, transport, ICT and human resources) of the South African healthcare system also impacts very directly on the ability of women employed in the profession to all function as their profession requires, and on the ability of the health care professionals to deliver to women patients what are their patient rights.

1.2 All of these reasons provide solid motivation for why an effective National Health Insurance system that is to be established through the passing and

implementation of the NHI Bill is critical for the emancipation and development of women, and in particular women from the poor and working class urban and rural communities. The submission intends to address the nature of the challenges that the NHI must address in each of these to substantiate the comment on the NHI Bill in section 2.

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2. COMMENT ON THE NHI BILL

2.1. We welcome the National Health Insurance (NHI) Bill in that it confirms Universal Health Coverage (UHC) through a single payer system as the platform for the delivery of health care. The goal of UHC is to realise the right to comprehensive health care of good quality for everyone on the basis of need, while ensuring that no one experiences financial hardship in accessing the care they need. Comprehensive care includes promotive, preventative, curative, rehabilitative and palliative health services regardless of people's socio-economic or health status. The NHI should be funded through a solidarity mechanism where there is a cross-subsidy from the rich to the poor via taxation.

2.2. Although we are supportive of the principles that underpin the NHI, there are several reservations about whether the Bill can deliver UHC. More broadly, we remain deeply concerned about government's ability to steer this ambitious project in the context of South Africa's deep-seated and multi-pronged health crisis.

2.3. Administration of the NHI Fund

2.3.1. The Bill makes clear that the NHI Fund will be overseen by a Board of ten persons appointed or approved by the Minister. It will be the only purchaser of health services from accredited providers – public and private – and will ensure equity and efficiency in health care. A unitary system with the National Health Insurance Fund (NHIF) as the single purchaser of services allows for strategic purchasing of those services that are necessary to reach defined health goals.

2.3.2. A justifiable concern, expressed by a number of analysts and based on experience of state-owned enterprises, is the potential that exists for this enormous fund to be looted.

2.3.3. Services free at the point of use will be provided to permanent residents while documented refugees and asylum seekers will be eligible

for free emergency services, care for conditions of public health importance (presumably TB, HIV and other infectious diseases) and services for paediatric and maternal conditions.

2.3.4. Services not reimbursed by the fund (i.e. not part of the defined 'package') can be paid for through medical schemes or out-of-pocket. All users are required to be registered with a primary care provider (presumably a clinic, health centre or general practitioner) and will have to attend such a provider before being eligible for specialist care.

2.4. **Services provided under NHI**

2.4.1. The details of what services are to be funded (the benefit package) are not provided. It is hoped that the benefits package will be identical for all users of NHI-funded providers. However, the Government Gazette of July 2017 titled 'NHI Implementation: Institutions, bodies and commissions that must be established' describes the proposed funding arrangements for five different groups: the unemployed, the informal sector (such as taxi industry; hawkers, domestic workers), those in formal sector employment (bigger business), those in formal sector employment (small and medium size business), civil servants (including SOEs, Intelligence Agencies, Defence, Police Service). This is a concern, since it implies that there will be different packages for different groups. Although this arrangement is said to be 'transitional', experience from other countries shows that it is very difficult to change such benefits packages once they have been in place for any length of time. It is likely that the poorest and sickest in our country will receive the most limited package of services. If this occurs it will increase already existing inequality.

2.4.2. A 'Benefits Advisory Committee' will decide what the content of these packages will be. This important body has representation from all medical schools, provinces, private hospitals, medical schemes and the World Health Organisation (WHO) but none from civil society or labour. This will be supported by a Health Benefits Pricing Committee which also has only technocrats.

2.4.3. There is no room in these committees for meaningful public participation. This will bias their work and decisions towards hospital-centred specialist care and a narrow biomedical approach. It is essential to include civil society and labour on these committees.

2.4.4. Their proceedings should also be open and transparent, and accountable to the Minister and Parliament. In particular, they must be

accountable for the reasonableness of their choices of the benefits they include in the package. The reasoning behind their choices should be open to public scrutiny, including the evidence upon which they are based and how they apply in local contexts.

2.4.5. Only the Stakeholder Advisory Committee, a large body that merely advises the Minister, has representation from indigenous practitioners, NGOs and civil society, although they are greatly outnumbered by representatives from professional and statutory bodies.

2.5. **How will NHI purchase services?**

2.5.1. Purchasing of services is intended to be devolved to provincial and district level hospitals and at sub-district level to contracting units for primary health care. District Health Management Offices are intended to play a coordinating role.

2.5.2. Justifiable concern has been expressed about whether these sub-district and district entities will have the capacity to undertake such detailed and complex activities. The mechanisms for payment of accredited service providers are vague in the Bill and it is strongly rumoured that medical schemes may be enrolled to perform this function. The concern that the greater likelihood of urban and private providers being accredited than public and (especially) rural providers, holds the danger of aggravating already existing urban/rural inequity. For example, the great majority of medical specialists and therapists of various kinds are overwhelmingly located in large metros, especially in Gauteng and Western Cape. This effectively means that public tax money will be used to fund a service that will likely cater preferentially for the better-off living in urban areas.

2.6. **Transitional arrangements**

2.6.1. The Bill specifies transitional arrangements that consist of three phases extending to 2026. The current second phase will focus on establishing institutions that will form the basis for the Fund, as well as on interim purchasing of personal health care services. Phase 3, from 2022 to 2026, will establish the necessary structures and be guided by two committees – the National Tertiary Health Services Committee and the National Governing Body on Training and Development. These will be responsible for Human Resources for Health (HRH) development plan.

2.6.2. The two concerns about these arrangements: Firstly, an HRH plan is required urgently to ensure the development of a robust public health

sector, especially at district level and below, so that the NHI can operate effectively and efficiently in formerly underserved areas. Secondly, given their unimpressive record to date in transforming health sciences education and training, it is unlikely that these structures, whose composition has been proposed to include mainly hospital-based clinicians and educators, will implement an appropriate HRH plan.

2.6.3. The Ministerial Advisory Committee on Health Care Benefits will be a precursor to the Benefits Advisory Committee which will advise the Minister on priority setting. Although the composition of this structure is not specified in the Bill, the 2017 gazette discussed above proposed a composition in which senior government officials and medical scheme representatives predominated. This structure too creates a concern that the emphasis will be on facility-based clinical medicine and that primary and community-level care will be marginalized, as will prevention activities.

2.7. The context: the national health crisis

2.7.1. While the crisis in the public health sector is front-line news today, the private sector is in a crisis of its own — a crisis of growing medical scheme unaffordability, shrinking benefits and static or declining membership.

2.7.2. The roots of the crisis lie in the systematic underdevelopment and structural inequality enforced by apartheid. Its more immediate cause is the neoliberal Growth, Employment and Redistribution (GEAR) macroeconomic policy adopted by the ANC-led government in 1996. GEAR follows the free market fundamentalist mantra of public sector austerity, privatisation of public services and goods, trade deregulation and low corporate tax. It is failing in all 3 of its components: growth is poor, unemployment rampant, and we remain one of the most unequal countries in the world.

2.7.3. More than 2 decades of austerity, combined with a deepening culture of corruption, have aggravated both facets of the national health crisis. Firstly, the state has failed to address inequity in access to the social determinants of health (SDH) such as sufficient quality food, water, sanitation etc through poor service delivery and growing unemployment and income inequality, thus aggravating the burden of disease. Secondly, the tight financial constraints imposed on the public health sector by austerity, together with a growing and increasingly pervasive culture of corruption, has led to loss of posts and skills, deteriorating infrastructure,

and demoralisation of staff at all levels of the system. The fact that rigid austerity was forced on the public sector in the face of the burgeoning and badly-managed HIV-AIDS pandemic of the 1990s made it all the more devastating.

2.8. **Strengthening the public health sector**

2.8.1. Before the public health sector can participate in the NHI it will need to be strengthened substantially, especially in terms of its physical infrastructure, human resource base and their skills, especially in leadership and governance. These imperatives will require strong political will and significant funds. Government has little option but to provide such funding, since the current health crisis is untenable. Although the upfront financial commitment will be large, the returns on investment are potentially even greater – as a result of savings on long-term health care, improved economic productivity of a healthier workforce, and the multiplier effect in the economy of having a larger number of employed people, especially rural women.

2.9. **Financing the NHI**

2.9.1. The Bill says very little about possible sources of funding for the NHIF, but there are no real options other than through taxation and an end to austerity budgets. We believe that progressive income tax — a surcharge added to the normal income tax at an increasing percentage — would be the best option. The principle that those who can afford it pay more, while those who need more health care receive more care, also builds social solidarity. The retrogressive recent increase in VAT adds to the tax burden of poor and working class people and exacerbates inequity in access to the social determinants of health through increased prices on some essential commodities.

2.9.2. There is no doubt that increases in revenue from tax are necessary to strengthen the public sector and finance the NHI. This may be difficult politically, but we believe there is room for such increases. Forslund notes that, because tax brackets have increased faster than inflation, the tax burden on the middle class and the rich has decreased substantially over the past decades. He points out that if the government had merely kept personal income tax stable since 2005/06 – by raising tax brackets strictly at the rate of inflation – personal income tax would have added more than R150 billion to the present budget. This would have made financing the NHI easier even before raising additional tax.

2.9.3. The alternative to tax is to borrow, which means eventually paying more and more government income towards debt servicing and away from delivering services.

2.10. **Corruption**

2.10.1. It is also essential to root out corruption. Corruption weakens the state, delegitimises taxation, destroys public services, and ruins the social fabric. Corruption thrives in dark spaces where the public and private sectors meet. Forslund argues that "as long as the public sector isn't strong enough to provide basic services, but relies on "partnerships" and tenders, corruption will remain rampant".

2.11. There have been many responses to the NHI Bill, most of them negative, many containing uncomfortable truths about the state of the health system and the extreme difficulty of fixing it. But this strengthens the case for the NHI and an equitable health system based on UHC and the principles of Primary Health Care. The state, at present, does not have the capacity to deliver it. Nor can the corporate private sector, as is shown by abundant empirical evidence in the public health literature. This places a major responsibility on civil society to give the state critical support and mobilise the public around health.

3. ***SOME SA GENDER HEALTH DATA***

1.1. By mid-2018, South Africa's population stood at 57,73 million people (0,75% of the total estimated 7,7 billion world population in 2019. The female population in the country has remained stable year on year at approximately 51% (roughly 29,5 million girls and women) *StatsSA Mid-Year Population 2018*

1.2. **Fewer infants are dying but still too many**. In 2018, births were the main driver of population growth in South Africa. More than 1,2 million births were recorded, and survival rates among infants and children under-5, and post-HIV interventions have increased. The **infant mortality rate (IMR)** has declined from an estimated 53,2 infant deaths per 1 000 live births in 2002 to 36,4 infant deaths per 1 000 live births in 2018. On average, a South African woman will give birth to 2,4 children in her lifetime, which is 0,1 lower than the global average of 2,5. The birth rate was influenced by an increase of 0.2m migrants and a decrease in population due to 0.5m deaths, the impact of increased life expectancy.

1.3. **Fewer women die in childbirth, but still too many**. South Africa **maternal mortality ratio** was at level of 119 deaths per 100,000 live births in 2017,

down from 122 deaths per 100,000 live births previous year, this is a change of 2.46%. The Maternal Mortality Ratio includes deaths during pregnancy, childbirth, or within 42 days of termination of pregnancy, irrespective of the duration and site of the pregnancy, for a specified year.

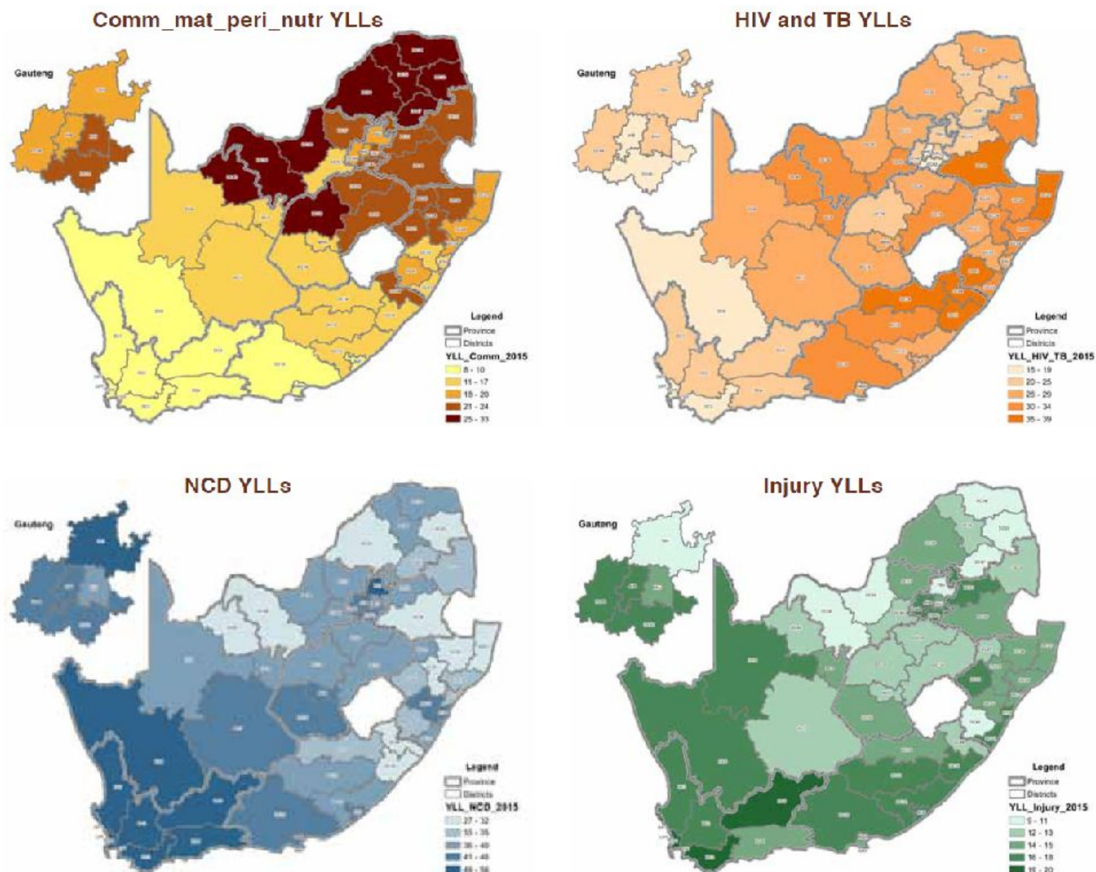
1.4. **People are living longer, with a significant elderly women population.** Life expectancy in SA has been increasing since 2007. By 2018, life expectancy at birth was estimated at 61,1 years for men and 67,3 years for women. The global life expectancy as at 2019 is 72,6 years. In South Africa, it stands at 64,2 years, indicating that SA lags 8,4 years behind the global average.

1.5. **South Africa faces a quadruple burden of disease, with particular impact on women**: the HIV/AIDS epidemic, along with a high burden of tuberculosis (TB); high maternal and child mortality; growing burden of non-communicable diseases; and high levels of violence and injuries. Disease burden is the impact of a health problem as measured by financial cost, mortality, morbidity, or other indicators. It is often quantified in terms of quality-adjusted life years (QALYs) or disability-adjusted life years (DALYs), both of which quantify the number of years lost due to disease (YLDs), and the Years of Life Lost (YLLs) due to disease. **Years of Life Lost** is a reflection of premature deaths, of deaths before reaching the life expectancy. An effective prevention focused health care system should result in a significant reduction in the Years of Life Lost due to disease or unnatural causes.

1.6. **There are significant income and spatial variances in the impact of disease burden and healthcare access.** In a country like South Africa which is so riven by spatial, racial, class, gender socio-economic inequality and unevenness of development, the analysis of the burden of disease based on social class or family income level as a proxy for class, on spatial location, on gender and on race becomes critical in health care planning. Health data is not readily available in a manner that enables this socio-economic analysis of the disease burden, but the diagrams below provide a close proxy to the required information. Neither Stats SA nor most research unpacks the manifestations of disease burden based on income levels, on spatial location, or on the level of service to the community. However, the research done by Health Systems Trust provides a useful reflection of the geographical mapping of disease burden in each of the four categories of disease burden. A useful addition to the mapping below would be the mapping of the worsts serviced municipalities, a concept that has been used across the 25 years of

democracy to reflect the impoverished, largely working class, and largely rural and former homeland district municipalities.

Map 2: Percentage of years of life lost (YLLs) by broad cause by district, 2015



Note: These percentages do not give any indication of the level of mortality due to these causes as would be provided by age-standardised mortality rates, but only of the relative proportion of all YLLs in each district due to each broad group of causes. Thus the percentage of YLLs for the four broad causes totals 100% for each district.

[1]

2. *COMMUNICABLE DISEASES*

2.1. **Tuberculosis** maintained its rank as the leading cause of death in South Africa, albeit with declining proportions (down to 6,5% in 2016 from 8,3% in 2014). Diabetes mellitus (5,5%) was the second leading natural cause of deaths followed by other forms of heart disease and cerebrovascular diseases both ranked third place at 5,1% each. Based on provincial differentials

[1] from Health Systems Trust publication Section on Burden of Disease by Pam Groenewald, Debbie Bradshaw, Candy Day and Ria Laubscher

diabetes mellitus in Western Cape, other forms of heart diseases in Gauteng and influenza and pneumonia in Limpopo were the leading underlying natural causes. For the rest of the provinces tuberculosis was the top-ranked natural cause

2.2. **Human immunodeficiency virus** [HIV] disease moved from the sixth position in 2014 and remained on the fifth position for both 2015 and 2016 deaths. *from Key findings: P0309.3 - Mortality and causes of death in South Africa: Findings from death notification, 2016 StatsSA website*

2.3. **Tuberculosis** Information on the leading causes of death by sex showed that in 2016 more male deaths (7,6%) were attributable to tuberculosis, while most female deaths (7,2%) were due to diabetes mellitus. Tuberculosis moved from the third position in 2015 to the fifth position for females in 2016, while among males diabetes mellitus ranked sixth in both 2015 and 2016. *.from Key findings: P0309.3 - Mortality and causes of death in South Africa: Findings from death notification, 2016 StatsSA website*

3. ***NON-COMMUNICABLE DISEASES***

3.1. For the first time, since 1997 **diseases of the circulatory system** were the top ranking underlying main group of natural causes. Generally, non-communicable diseases accounted for 57.4% of deaths in 2016 while communicable diseases were responsible for 31,3% of deaths in 2016.

3.2. High blood pressure, or hypertension, is one of the most serious risks factors for death from heart diseases and strokes, responsible for 13% of all deaths globally. An estimated 53 men and 78 women die in South Africa each day from the impact of hypertension. In South Africa more than 1 in 3 adults live with high blood pressure and it is responsible for 1 in every 2 strokes and 2 in every 5 heart attacks. High blood pressure is known as a 'silent killer' because there are rarely any symptoms or visible signs to warn that blood pressure is high. That is why more than 50% of people with high blood pressure are unaware of their condition. In some cases, typically with very high blood pressure, symptoms such as headaches, visual disturbances, nose bleeds, nausea, vomiting, facial flushing and sleepiness may be experienced.

3.3. Blood sugar problems and diabetes are highly prevalent in South Africa and amongst South African women in particular. Recent data from the International Diabetes Federation (IDF) estimates that 7 % of South Africans between the ages of 21 and 79 years have diabetes (1). Based on the latest

population estimates for South Africa (2), this means that 3.85 million South Africans in this age group may have diabetes. However, these statistics only shed light on the surface of a much deeper problem. In 2010, the prevalence of type 2 diabetes in South Africa was estimated at 4.5 % (3). Thus, a 155 % increase in 6 years!

3.4. According to statistics from the National Cancer Registry (NCR) 2014, the top five cancers affecting women in SA include: breast, cervical, colorectal, uterine and lung cancer. Both **breast** and **cervical** cancer have been *identified as a national priority with increasing incidences occurring*.

3.4.1. Approximately 19.4 million women aged 15 years and older live at-risk of being diagnosed with **breast cancer** – the cancer affecting women in South Africa the most. In 2013, deaths from breast cancer and cancers of the female genital tract, accounted for 0.7% and 1% of all deaths in South African respectively. Awareness of the **symptoms**, and early detection through screening, can help lead to earlier diagnosis, resulting in improved treatment outcomes. Awareness of **risk factors**, can help women reduce their personal cancer risk.

3.4.1.1. Importantly cervical cancer is a preventable disease. The ability of the NHI to ensure that all girls are able to receive the immunisation against the **Human papillomavirus (HPV) and thereby be protected from cervical cancer is critical.** Worldwide, cervical cancer is the fourth most frequent cancer in women with an estimated 570 000 new cases in 2018 representing 7.5% of all female cancer deaths. Of the estimated more than 311 000 deaths from cervical cancer every year, more than 85% of these occur in less developed regions.

3.5. **Mental Health**

3.5.1. Mental health impacts on South African women in multiple senses. The burden of mental illness falls on women as mothers and as prime care givers, while at the same time women experience their own burden of mental illness. The NHI as a system of ensuring equitable access to health care must ensure that this double burden of mental health on women is addressed.

3.5.2. **Address the considerable need for the placement of social workers, psychologists and counsellors in government schools.** It is deeply concerning that 25 years into democracy, a private school may have 3 psychologists or a multidisciplinary team of healthcare providers in their school, but government

schools have none of these. Inequality in healthcare exists not only on hospitals and clinics, but in many other settings such as schools. Children or teenagers may witness or be victims of trauma at home or at school. If their trauma is not addressed the potential psychological consequences are far-reaching. These consequences include low self-esteem, academic deterioration, nightmares, social withdrawal, anxiety, concentration problems, depression, nagging self-criticism, loss of energy, Post-Traumatic Stress Disorder and even suicide.

3.5.3. **More counselling services for teachers in schools.** Given the high levels of trauma in South Africa, such as the gender-based violence epidemic, it is highly likely that many teachers across the country have been victims of gender-based violence. If teachers are impacted by gender-based violence and do not have access to counselling services, this can impact their occupational functioning, their relationship with learners including their mood and the way they communicate with learners, their motivation to teach, and subsequent mental illness such as Depression or PTSD.

3.5.4. **Address the need for more child mental health services in hospitals and clinics, as well as addressing the lack of funding for child mental health services in clinics and hospitals.** Currently, child mental health services in government hospitals consist only of primary healthcare. There are few specific child mental health services, there is a lack of funding for child mental health services and child mental health services are simply not prioritised. Because of this, situations where children are placed in psychiatric wards with adults are commonplace. When these children are placed with adults in these wards, stories of these children being raped or sexually abused occur frequently. Furthermore, there are few therapy services in the clinics for these children to receive therapy or play therapy if they have experienced gender-based violence. The consequences of early childhood trauma can be lifelong. These include Borderline Personality Disorder, Depression, Substance abuse, Generalised Anxiety Disorder and Post-Traumatic Stress Disorder. To quote slavery abolitionist Frederick Douglass, “It is easier to build strong children, than to repair broken men.”

3.5.5. **A countrywide audit into the quality of inpatient psychiatric wards in government hospitals** There are inpatient psychiatric wards where there are more patients than beds in a ward, as well as wards that do not comply with hygiene standards. Healthcare is a human right, and many inpatient psychiatric wards are simply not fit to address the healthcare needs of inpatient

psychiatric patients. A review and an audit into the state and quality of inpatient psychiatric wards in government hospitals countrywide must be incorporated into the process of the implementation of the NHI.

3.5.6. **Mental health taught as a subject in schools** The implementation of the NHI must enable a new approach to public health education. Currently, mental health or psychology is only offered as an optional course at universities and colleges. Mental health is not included in our school curriculum. Because of South Africa's long history of trauma, the current high levels of crime in our country such as armed robberies, hijackings and gender-based violence, and the resulting mental illnesses that may occur from these traumas such as depression, anxiety, Post-Traumatic Stress Disorder and Generalised Anxiety Disorder, there is a considerable need to educate the youth on mental health and mental illness. By educating our youth, we would be able to teach them essential coping skills. These coping skills include stress management, conflict management, self-awareness, how to help a friend or family member with a mental illness, understanding substance abuse and many more. School is not only about academic performance, but it is about the development of character and manners as well as building relationships and learning how to cope with different life challenges.

3.5.7. **Teaching the concept of active citizenry in schools** A common trend from the stories of gender-based violence that I have heard, are that communities, friends and family stay quiet or even stigmatise victims of gender-based violence. Psychologically, an abuser or bully will always interpret silence as approval for their behaviour. Furthermore, from personal observation, it appears that as a society we are silent until there is a disaster. In other words, we go from a state of persistent denial, to ultimately a state of despair with no earlier active citizenry taking place. It is extremely reactive. Therefore, it is recommended that the concept of active citizenry be incorporated into the school curriculum from an early age. The hope is that early active citizenry education, will educate children about the importance of developing a democratic voice and instinctively fighting against injustices like gender-based violence when instances of gender-based violence in their communities arise. To quote Dr Martin Luther King, Jr "There comes a time when silence is betrayal." If we stay silent, then that girl you know who was raped, may end up committing suicide.

3.5.8. **Mental health training for children, parents and teachers** Patients who have experienced serious violent crime will often have setbacks during the

therapeutic process due to incidences in their homes and communities. Community projects where, mental health topics are presented to communities in city halls or in schools can assist in addressing this. *Relevant topics of interest include:*

- The psychological impact of gender-based violence
- Understanding substance abuse
- Bullying and cyberbullying
- Teamwork training
- Stress management
- Conflict management
- Leadership development
- Mental health awareness
- HIV/AIDS awareness
- Depression
- How to cope with trauma
- Leadership development
- Parenting education
- Emotional intelligence

4.7 Substance Abuse and Addition

4.7.1 **Substance abuse must be addressed through the NHI rather than addressed through the criminal justice system, which should focus on the illegal manufacturing and sale of intoxicating substances.** The interface between substance abuse, of both alcohol and heavy drugs, and inter-personal violence is well known. Here again there are a number of ways in which substance abuse impacts on women – as mothers of substance abusing children, as substance abusers themselves, and as partners and wives of substance abusers.

4.7.2 *There are multiple concerning statistics regarding substance abuse in South Africa.* 60% of crimes in South Africa are related to substance abuse. The harmful use of alcohol abuse, a mental illness, results in 2,5 million deaths per year. 12% children start drinking before the age of 13. On average, 86 sick days of absenteeism occur at work due to alcoholism. 21.4 adult males are dependent on alcohol. On-the-job supplies of drugs and alcohol account for 15 to 30 per cent of all accidents at work. For workers, substance abuse can result in deteriorating health, injury, disciplinary action, family problems, job loss, and therefore poverty and social deprivation. Employees with chemical dependence problems may claim three times as many sickness benefits and file five times as many workers' compensation claims. Absenteeism is two to three times higher for drug

and alcohol users than for other employees. There is a strong correlation between Nyaope use and school failure. It is strongly recommended that schools, communities and families are educated with substance abuse training programmes.

4.7.3 **Address the easy accessibility of drugs and alcohol such as local drinking spots that don't have liquor licences and allow underage drinking** It is imperative that in the fight to eradicate gender-based violence, all precursors that can lead to crimes like gender-based violence be eradicated. It is commonplace for taverns and bars to not have liquor licences and allow underage drinking. This needs to be addressed as soon as possible.

4.7.4 **Assess the access and quality of rehabilitation facilities in poor communities** R2,700 a day in a private clinic will get you a scenic garden, swimming pool, private rooms, 60 beds and nine in-house psychiatrists. In a government institute or hospital only the most severe cases get admitted and on average, there is one psychiatrist for every 350 000 patients. A drive through Kagiso, Alexandra, Soweto, Eldorado Park or Mamelodi how many rehabilitation facilities would one see? Addiction is a mental illness. Many addicts in poor communities remain untreated because of mental health stigma as well as a lack of access to healthcare. The knock-on effects of a lack of access to substance abuse rehab facilities are far-reaching. These include, gender-based violence, job loss, crime, illness and ultimately death. A lack of access is a denial of a fundamental human right.

4.7.5 **Mental illness as a result of bullying and harassment**

4.7.5.1 **Bullying education for parents, teachers and communities** Physical, verbal and psychological bullying from a young age often serves as a precursor for gender-based violence in adulthood. Examples of bullying from a young age include hitting, punching, name-calling, gossiping, intimidation, initiating physical fights, using weapons that can cause serious harm to others, stealing while confronting a victim and cruelty to people and animals. A deep concern regarding the development of a bully, is that young children are witnessing gender-based violence in the home. They may perceive this violence as normal or feel that the way to solve conflict is through violence. Therefore, these children may subsequently bully children at school after role modelling the behaviour of their parents. Furthermore, these children may be taught about bullying in schools, but when they return home, they may experience parental or sibling bullying which may nullify the bullying education they receive at school. Because of this, educating parents, teachers and communities on the psychological impact of bullying is strongly recommended.

4.7.5.2 **More anti-bullying programmes in schools** The process of addressing bullying requires a holistic effort. An "as-and-when" mentality whereby bullying is addressed as-and-when an incident arises won't work. There are numerous long-term psychological implications for bullying. These include depression, PTSD, anxiety, low self-esteem and even suicide. Because of this, a proactive approach to bullying needs to take place in the form of anti-bullying programmes. *A typical anti-bullying programme may consist of the following:*

- Create specific class rules against bullying.
- Co-operative learning activities at school.
- Praise for pro-social and helpful behaviour by learners.
- Facilitate class meetings about bullying.
- Counselling for bullying victims.
- Counselling for perpetrators. (A child who bullies is still a child)
- Bullying taught as part of the school curriculum.

4.7.5.3 **Improve anti-bullying legislation across all schools** Given the long-term consequences of bullying such as low self-esteem, anxiety, depression, PTSD, and even suicide, strong anti-bullying legislation is imperative. If the consequences of these actions are prevented sooner, then hopefully this can play a role in preventing gender-based violence in adulthood.

4.7.5.4 **Gender-based violence in universities** Many students who experience rape, GBV or sexual harassment fail to achieve academically, with the potential consequences of dropping out of university both for their own lives and negative consequences for the country in the form of loss of graduates, increased unemployment increased mental health burden . The survivors of GBV may experience mental illnesses as a result of their trauma. These include substance abuse, Depression, Social Phobia, Panic attacks, PTSD, Borderline Personality Disorder and Generalised Anxiety Disorder. The interface between the NHI and the wellness and health care and counselling services in further and higher educational institutions is critical in addressing this situation.

4.7.5.5 **Human rights to be taught as a subject in schools** Many children and teenagers, and even adults who have been victims of gender-based violence, simply don't know their rights or don't even think about their rights. In a democracy, it is deplorable that so many adults are this disempowered. There is an alarming problem of a lack of active citizenry in South Africa. The incorporating of human rights education and education on the constitution into the school syllabus. can empower South Africa citizenry.

4.7.5.6 ***Revise school hate speech policies*** Hate speech at schools, such as racism, sexism, homophobia, transphobia, Islamophobia and anti-Semitism occur regularly. There is a psychological process called internalised oppression.

When a person experiences oppression over a period, if the victim believes the abuser, this can re-shape their mindset to the point where the victim feels they are undeserving. Undeserving of a good job, undeserving of a good relationship, undeserving of happiness and undeserving of a good life. The victim can believe that they are "less than" because of the impact of their discrimination. This is known as a process called internalised oppression. In other words, the victim may oppress themselves as result of their discrimination they have experienced over time. Therefore, strong hate speech policies are recommended for schools.

4.7.5.7 Physical exercise is a fundamental part of a health regime and the NHI implementation should ensure the interface between physical activity and exercise as part of preventative health care. There are multiple benefits of physical activity and exercise, which include the development of leadership skills ; teamwork; Interacting with people of difference races, cultures and religions; Self-discipline ; Self-confidence; Commitment; Being empowered and empowering others; Strengthening of character; Coping under pressure situations; The boost of endorphins; Reduced anxiety; A sense of purpose; and Improved sleep. There are few schools and municipalities which have sporting facilities such as tennis courts, soccer fields, cricket nets, and swimming pools. Furthermore, most of these schools don't offer extra murals in the afternoon. Because of this, children and teenagers are roaming the streets after school which makes them susceptible to drug lords and other dangerous elements. The development of more sporting facilities and resources in poorer communities. The development of sports academies in poorer communities. The development of more sports coaches. More scouts in poorer communities looking for future talent.

4.7.5.8 ***The LGBTQIA+ community*** In the South African context, homophobia and corrective rape are still common. Furthermore, in the healthcare sector, the LGBTQIA+ community may experience discrimination. Finally, the impact of homophobia and corrective rape may have far-reaching psychological consequences. *The following suggestions are recommended for the LGBTQIA+ community:* Assess if schools are making it safe for children and teenagers to come out. More counselling services for victims of homophobia and corrective rape. More medical facilities, affordable medication and surgery, and counselling for the transgender community. There are few hospitals that provide gender-reassignment surgery and prescribe hormone replacement therapy. The suicide rate in the transgender community is at 70%. Educate children on LGBTQIA+ matters as well as the psychological impact of homophobia and corrective rape. Harsher punishment for police stations who

treat corrective rape victims dismissively. More community and parental education on LGBTQIA+ matters.

4.7.6 **Employee wellness** The NHI implementation must ensure that there is an appropriate interface between preventative and primary healthcare services such as employee wellness programmes and the formal health care system. There is evidence of the positive consequences of companies that use employee wellness providers, including less staff conflicts, Less absenteeism, less sick time and employee turnover, Increased productivity, efficiency and profitability, Increased morale and loyalty, Less need to recruit and train new staff, Decreased worker's compensation claims., staff members are more motivated and purposeful, the company's reputation is enhanced. Therefore, the following is recommended that employee wellness is legislate, and non-compliance should be sanctioned; that all employee wellness companies should register with NHI; and that companies should receive strong punishment for mental health discrimination such as mental health stigma and other forms of discrimination.

4.7 **Disability**

4.7.1 Many health facilities remain inaccessible for persons with disabilities, and this places a burden on women in two senses – women with disabilities experience difficulty in accessing healthcare facilities, but women who are by and large the majority of carers of people which disabilities have to manage the lack of adequate access for those for whom they offer care. The NHI must ensure that access and appropriate service for people with disabilities is addressed in all health facilities, including the following:

4.7.1.1 Built environment of many clinics and hospitals is still not accessible for wheelchair users, or people using walkers, leg braces or crutches.

4.7.1.2 Communication barriers for Deaf and hard-of-hearing persons result in non-compliance with medication prescribed; not accessing health services timeously; and no means of accessible communication during hospitalisation (inclusive of ICU)

4.7.1.3 Access to information remains inaccessible for many persons with print disabilities (e.g. blind and dyslexic persons)

4.7.1.4 Negative attitudes and lack of disability literacy and confidence among health workers Transport access for persons with mobility disabilities remains a critical, and potentially life threatening, barrier – if you cannot get to a facility, you cannot access the service

4.7.1.5 Persons with disabilities often need regular 'specialised' health services currently not available at local level. They cannot afford to travel to the district/tertiary level facilities where such services are available, and as a result

have very poor health status. Their families are also unable to provide support during long hospitalisation due to the cost of transport and accommodation

4.7.1.6 Mental health care services – in particular access to community-based services providing alternatives to institutional care, as well as quality of services (often life threatening) in mental health institutions, remain a major challenge (Life Esidemeni is but the tip of the iceberg)

4.7.3 Long waiting lists for services such as cancer treatment, orthopaedic treatment (hip/shoulder/knee replacements etc) exacerbates the severity of impairment and often cause secondary disability

4.7.4 The NHI must address **disability specific health services, in particular rehabilitation and assistive devices, and the appropriate rehabilitation human resources.** Rehabilitation human resources (therapists, psychologists, orthotists etc) are not recognised as an essential scarce skill and the Health HR Strategic Plan therefore makes insufficient provision for rapid expansion of availability of rehabilitation personnel at all levels of care. Current provisioning at clinic, CHC and hospital level in the majority of districts outside metros hardly have sufficient staff for assessment, with virtually no provisioning for actual rehabilitation treatment on regular basis.

4.7.5 Very few provinces currently provide intermediate and post-medical rehabilitation services, and where such is available (Western Cape, Gauteng), they are located in urban centres with long waiting lists. This hampers our efforts to liberate persons with disabilities educationally and economically. The WPRPD advocates that every province has at least one comprehensive provincial specialised rehabilitation centre that covers ALL impairments

4.7.6 There is for example are no health/rehabilitation facilities providing interventions for deaf or blind children and adults

4.7.7 Early identification and intervention services for children with autism is only available in the main metro's.

4.7.8 Hearing families of Deaf babies and Deaf babies themselves have NO public service to introduce communication and language through SA Sign Language, resulting in significant educational as well as mental health challenges

4.7.9 The majority of provinces provides the bare minimum in assistive devices (wheelchairs, crutches, hearing aids, some also white canes and spectacles, seating for children with disabilities), and even this bare minimum has waiting lists of up to 6 years for a basic device. This is perhaps the biggest reason for education and economic exclusion, yet it can be easily addressed with a focused budgetary and provisioning system intervention. The announcements that the NHI Fund would prioritise hearing aids and spectacles do not nearly touch the enormous need out there.

4.7.10. Women bear the brunt of the burden of care where persons with disabilities have been unable to achieve maximum independence due to lack of accessible, affordable and available health and rehabilitation services – it is therefore very much a service that has borne the brunt of gender discrimination and marginalisation intersected with disability discrimination and marginalisation.

4.7.11 The sector has made quite detailed submissions during the NHI White Paper process, but all their appeals for a focused session with the NHI secretariat across all disability types have, according to the sector, fallen on deaf ears.

5. *WOMEN'S REPRODUCTIVE HEALTH*

5.1 Girls and women have a unique life cycle that is essential for the reproduction of the human species. The management of this life cycle has historically been a site of either oppression and subordination of women or of the enabling of girl and women's societal participation and development. This unique life cycle has both health management dimensions and cultural taboos and practices. The role of the National Health Insurance in ensuring that all girls and all women have access to health education in relation to their biological functioning, in relation to the health management of their reproductive health cycle throughout their life time, and to information that can enable girls and women not to be constrained by archaic and reactionary cultural taboos and practices cannot be under-estimated.

5.2 The unique life cycle of women's reproductive health and its health management dimensions include the onset of puberty and menstruation, ongoing menstrual management, contraception, pregnancy management, including the operationalising her right to terminate pregnancy, childbirth, breastfeeding and infant care, postpartum depression, and finally menopause. This entire process is a natural process, it is not a disease, but it is a cycle that requires access to health care systems. Each stage of this life-cycle requires women to be able to access health education, health services, medication and equipment even if she does not face any illness in relation to her reproductive health. This is a most fundamental right of girls and women, and one without which her participation in society can be severely limited.

5.3 The NHI must enable all girls and women to access sanitary pads or a menstrual cup from the onset of her menses. It must equally ensure that all girls of sexual consent age and all women who are sexually active are able to access contraception, in order to have control over decision making about falling pregnant as well as for protection against STDs/STIs and HIV. The right to

terminate one's pregnancy in a safe and healthy manner is a right enshrined in SA law, and must be accessible for all girls and women covered by the law. Girls and women who are pregnant must be able to access regular check-ups to ensure that both the mother-to-be and the foetus have the best options for full health, and must be able to have a health practitioner supervised birth, with appropriate intervention capacity as may be required. All girls and women who have given birth must be able to access the necessary post-birth health care including the monitoring of the growth of the new-born and their immunisation. All women who reach the end of their child-bearing years and move into menopause must be able to access the health care services that support this hormonal transition in the interests of the women.

5.4 There are key indicators that South Africa has significant challenges in relation to women's reproductive health rights. Teenage pregnancy is alarmingly high and worse there are areas in which pre-teen pregnancy is prevalent. The figure on school learners who have given birth to a child is a reflection of this societal problem.

5.5 The extent of abortion in health care facilities and in unsafe and unauthorised facilities is a reflection of the demands that this will place on the NHI.

5.6 The maternal mortality rate discussed above is to high and the NHI is critical for its reduction. But of more concern is that provincial unevenness, in relation to maternal mortality. The NHI must address the above average risk of maternal death, death in childbirth in provinces such as North West >>>>> check on the latest figures pre province.

5.7 **Infant Mortality Rate** Infant mortality rates can be connected to the level of healthcare and nutrition that the mother received during her pregnancy, can relate to the level of healthcare provided in the birth process, and can relate to post-birth health and social support to mother and infant. Every child born in South Africa is born with the same rights enshrined in our Constitution and without the NHI, this right to survive and thrive through infancy into childhood and then into adulthood cannot be ensured for all new-borns.

6 *UNNATURAL CAUSE HEALTH BURDEN*

6.1 Overall, 405 370 (88,8%) deaths that took place in 2016 were due to natural causes and 51 242 (11,2%) were attributed to non-natural causes. The unnatural deaths were down from 17% in 1997 but up from the lowest of 8% in 2006 and again in 2009 (Stats SA P0309.3 2016) The proportion of deaths due to non-natural causes were higher for males compared to females at all ages, with the

proportions of deaths due to this group particularly high for males aged 20-24 years (66,1%). By province of death, Western Cape (13,3%) had the highest proportion, followed by KwaZulu-Natal (12,1%) and Eastern Cape (11,7%). All these provinces exceeded the aforementioned national average of 11,2% of deaths. These un-natural deaths of girls and women include those from femicide, the death of women usually at the hands of men, and very often of men that they know well or intimately.

6.2 It is important to acknowledge that behind these unnatural deaths is a massive health burden of unnatural health care needs, be it from accidents, or from violence. In relation to girls and women, boys and the LGBTQI+ communities the extreme scourge of gender-based violence requires women to be able to access health care services for treatment of physical violence, rape, and emotional or mental violence. The National Health Insurance scheme is a critical mechanism to ensure that every victim of gender-based violence is assisted to become a survivor of gender-based violence through equal access to health care services that they require.

6.3 The relationship between healthcare and guns Currently in South Africa, femicide is five times higher than the global average. The killing of woman like Reeva Steenkamp, Leighandre Jegels, Jesse Hess and Meghan Cremer are examples of this atrocity. Many patients who I help are grieving the loss of family members and friends who have been victims of femicide, hijackings and armed robberies. Gun violence is at the heart of all these crimes. Therefore, the following three recommendations to address gun violence need to be addressed. These recommendations can hopefully have a positive knock-on effect on the healthcare sector. These include: *Stricter gun laws need to be put in place and gun law legislation needs to change. Address the easy accessibility of guns. More counselling services for people who have lost family members, friends and colleagues due to crimes like femicide, armed robbery and hijacking.*

7 WOMEN AS FAMILY AND COMMUNITY CARE GIVERS

7.1 As has been reflected throughout this document the gender division of labour in the family and patriarchy determine that women remain the primary care givers of babies, children, people with disabilities, the ill, and the elderly. The inadequate access and service provision by the health care system thus places a direct burden on women, with particular bearing on women from working class, informal and rural communities. The successful implementation of the NHI, in moving South

Africa towards universal access to healthcare services will impact positively on the lives of women, girls as well as adults, who functions as care givers.

8 ONGOING PATRIARCHAL ATTITUDES AND PRACTICES OF THE MEDICAL PROFESSION

8.1.1 The implementation of the NHI entails a new approach to the provision of health care services to the citizenry in line with the hypocritic oath and the Constitution. In the implementation of the NHI, South Africa has an opportunity to address many challenges that still bedevilled the healthcare profession. There is extensive evidence of the negative impact of patriarchal and elitist attitudes on women in the health profession that must be eradicated.

9 ABILITY OF WOMEN EMPLOYED IN THE PROFESSION TO ALL FUNCTION AS THEIR PROFESSION REQUIRES

9.1 The NHI in ensuring that all health professionals are able to function in lines with the obligations of both the medical professional code and the Constitution will empower women health care professionals to rise to deliver according to the professional expectations. The resourcing of health care facilities to enable this is a critical building block of the NHI.

10 IMPACT ON WOMEN'S PATIENT RIGHTS OF UNEVEN RESOURCING

10.1 The fact that the maternal mortality rate is far worse in certain provinces than in others, the fact that women in urban settings have better access to health care than women in the rural areas, are all issues that the implementation of the NHI seeks to address, and must address. The obligation of health of South African citizens cannot be one that is differentially affected by uneven resourcing of the health care system. Health is a right and not a commodity and as such the health care system is obliged to ensure that all people living in South Africa are supported by an equitable healthcare system. This right of women patients is not realisable for all girls and women in South Africa outside of the implementation of the NHI.

Ends