# Where are the children?
# Submission on the National Health Insurance Bill
# Opportunities and concerns for child and adolescent health

**Endorsed by:**

**Organisations**

- Children's Institute, University of Cape Town
- Department of Paediatrics and Child Health, University of Cape Town
- Centre for Child Law, University of Pretoria
- SACSOWACH (South African Civil Society for Women, Adolescent and Child Health)
- Division of Community Paediatrics, University of the Witwatersrand
- Primary Health Care Directorate, University of Cape Town
- Peoples Health Movement
- Gateway Health Institute
- Kheth'Impilo
- Child Nurse Practice Development Initiative, University of Cape Town

**Individuals**

- Dr Neil McKerrow, Department of Paediatrics and Child Health, Nelson R Mandela School of Medicine, University of KwaZulu-Natal
- Dr Elmarie Malek, Clinical Head of Department, General Paediatric and Neonatal Specialist Services, Tygerberg Hospital, Department of Paediatrics and Child Health, University of Stellenbosch
- Professor Haroon Saloojee, Division of Community Paediatrics, University of the Witwatersrand
- Professor Anthony Westwood, Department of Paediatrics and Child Health, University of Cape Town
- Professor Louis Reynolds, Department of Paediatrics and Child Health, University of Cape Town
- Associate Professor Diane Gray, Department of Paediatrics and Child Health, University of Cape Town
- Dr Gabriel Urgoiti, RX Radio
- Dr Elona Toska, Centre for Social Science Research, University of Cape Town
- Professor Catherine Mathews, Health Systems Research Unit, Medical Research Council
- Dr. Thandi Wessels, District Paediatrician Cape Town Metro East, Department of Paediatrics and Child Health, Tygerberg hospital, Stellenbosch University.

- Extraordinary Professor Linda Richter, DST-NRF Centre of Excellence in Human Development, University of the Witwatersrand
- Professor Ameena Goga**,** Senior Specialist Scientist, Health Systems Research Unit, Medical Research Council
- Dr Sara Nieuwoudt, School of Public Health, University of the Witwatersrand
- Professor Ashraf Coovadia, Academic Head of Department, Department of Paeditrics and Child Health, University of the Witwatersrand
- Professor Andrew Robinson, Faculty of Health Sciences, North West University
- Dr Jessica Price, MRC/Wits Rural Public Health Transitions Research Unit, School of Public Health, University of the Witwatersrand
- Professor Marius Smuts, Centre of Excellence for Nutrition, North West University
- Dr Zolile Mlisana, HoD – Department of Pediatrics, Mthatha Regional Hospital.
- Associate Professor Minette Coetzee, Child Nurse Practice Development Initiative
- Dr Deirdre Pansegrouw, District Clinical Specialist Team, Ilembe District, KwaZulu-Natal
- Dr Michael Hendricks, District Paediatrician, Metro West, Cape Town
- Alex Daniels, International Palliative Care Network
- Tinashe Njanji, People's Health Movement
- Lori Lake, Children's Institute, University of Cape Town

**Introduction**

We commend government's commitment to universal health coverage and welcome the opportunity to give comment on this important policy document as there are a number of significant issues that need to be addressed to ensure that National Health Insurance (NHI) addresses children and adolescent's special needs and vulnerabilities.

In particular, we commend the positive focus on maternal and child health within the re-engineering of primary health care (PHC) and it is important that this focus is reinforced and sustained.

**Motivation: Why prioritise child and adolescent health?**

Section 28 of the Constitution outlines children's right to "basic health care services", their rights to "care" and "protection", and to have their "best interests" considered of "paramount importance in any matter concerning a child"[1].

Yet despite these entitlements, children remain disproportionately affected by **poverty** with many experiencing multiple deprivations that accumulate over time creating long-lasting developmental setbacks,[2] with children in former 'homeland' areas and informal settlements continuing to experience the highest levels of deprivation. One in five children live in overcrowded households, 1 in 3 are without water on site, 1 in 5 are without basic sanitation[3] - so it is therefore unsurprising that diarrhoea and lower respiratory infections account for 21% and 18% respectively of under-five mortality.

Yet global and national efforts to improve child health extend beyond a focus on mortality. Increasingly attention has shifted to the burden of malnutrition as this undermines children's long-term health, education and employment prospects, while the growing burden of obesity and non-communicable diseases also has its roots in early childhood. It is therefore of concern that a quarter of young children in South Africa are stunted,[4] and 13% of young children are overweight with the burden increasing rapidly with age.

Growing evidence that **early intervention** is not only critical, but also the most **cost-effective** strategy in promoting children's optimal health and development, stemming the tide of NCDs, and breaking the intergenerational cycle of poverty. It is therefore vital that the NHI actively prioritises investments in child and adolescent health.

Equitable **access to health care services** is key given that one in five children still travel more than 30 minutes to reach a health facility,[5] and transport costs and safety concerns lead to life-threatening delays in accessing treatment. While a lack of "positive and caring attitudes"[6] undermines uptake of both adolescent health services[7] and antenatal care[8].

It is therefore vital that the health care needs of children and adolescents are explicitly factored in, and given priority within the NHI – paying particular attention to the most vulnerable children – including neonates, adolescents, children with disabilities and long term health conditions, foreign children and those living in rural areas and informal settlements – to ensure that no child is left behind.

**Specific concerns**

1. *Registration of users*

In order to access health goods and services under NHI, people must have **proof of registration. Registration can only be done at an accredited provider or health establishment**. Children born to users are regarded as having been **registered automatically at birth**. **Children already born** will need to be registered by their parents or can register themselves from age 12 onwards. **An original identity card, birth certificate or refugee identity card will be required for registration**.

This provision could result in barriers to health care for **undocumented children** whose births are not registered. Statistics South Africa's 2018 report on recorded live births reveals that of babies born in 2017, only 77.7% had their births registered within the 30 days of their birth. Birth registration was lowest in three districts in KwaZulu-Natal where fewer than half of births were registered in time: iLembe (51.8%); uMzinyathi (56.6%); and uThungulu (63.2%).[9]

In addition, there are concerns that public facilities serving poor, under-resourced and rural communities may not meet the standards for accreditation and this may create further barriers to registration and prevent those children most in need from accessing health care services.

If NHI is genuinely committed to promoting universal health coverage (UHC), and promoting health equity, then it is vital that the current accreditation and registration requirements are revised to ensure they do not introduce additional barriers to care or prejudice those children most in need.

2. *Eligibility - Defining a package of basic health care services*

We are pleased to see that the Bill specifically upholds the Constitutional right **of all children to "basic health care services".**[10]

However, we note with concerns that the state has **yet to define what "basic health care**" means in practice and how it translates into a package of essential health care services children and adolescents. It is therefore urgent to define "basic health care", and **ensure that a broad package of essential services** is put in place that promotes not only child and adolescent survival but also their optimal health and development. This should extend beyond treatment to include early intervention, prevention, rehabilitation and palliative care for children with long term health conditions.

It is therefore vital that the **Benefits Advisory Committee** engages with experts in child and adolescent health to develop appropriate baskets of care for children and adolescents. This should build on the work already done by the Committee on Mortality and Morbidity of Children under five (COMMIC) who have developed a framework for an essential package of health care services for children that includes children with long term health conditions and those requiring palliative care[11].

3. *The rights of foreign children*

People eligible for NHI include South African citizens, permanent residents, refugees, inmates, and "certain categories of individual foreigners determined by the Minister of Home Affairs, after consultation" with the Ministers of Health and Finance, while **asylum seekers and illegal foreigners are entitled only to emergency medical services and services for notifiable conditions of public health concern.** We are therefore pleased to see that the **Bill upholds the constitutional right of all children, including children of asylum seekers or illegal migrants, to basic health care services** as

provided for in section 28 (1)(c) of the Constitution. Yet children of asylum seekers and illegal immigrants will not have the formal **identity documents** required to register as users. Clarity is therefore needed on how these children will gain access.

It is also is not clear whether children's right to basic health care services extends **to antenatal and obstetric care.** Yet these are key determinant of children's health and survival and both pre- and postnatal care are therefore considered by the UN Committee on the Rights of the Child as an essential component of children's right to health.[12] We therefore call on the State to extend antenatal and obstetric services to asylum seekers and illegal foreigners.

While many South African children already receive a range of services that could be considered part of a basic health care package, others enjoy a range **of additional essential services** in the public sector that could potentially fall outside the defined basic package, but that are likely to be included in the benefits recommended for the NHI by the Benefits Advisory Committee. It is therefore unclear if the NHI Fund will cover these benefits for children of asylum seekers and illegal migrants as it will for South African children.

*4. Representation for child and adolescent health*

The Bill enjoins the minister to appoint advisory committees:

- The **Benefits Advisory Committee.** Its tasks include determining and reviewing the health care service benefits and types of services that the fund will pay for at each level of care from primary to tertiary hospitals. Its members must have technical expertise in medicine, public health, health economics, epidemiology, and the rights of patients. An additional member represents the Minister. There is no representation from organised labour or user groups.
- The **Health Benefits Pricing Committee**, which must recommend the prices of health service benefits. Members must have expertise in actuarial science, medicines, epidemiology, health management, health economics, health financing, labour and rights of patients. A member must represent the Minister. This is the only advisory committee with a defined number of members: "not less than 16 and not more than 24". The Bill does not say whether members with "expertise in labour and rights of patients" actually represent those constituencies.
- A **Stakeholder Advisory Committee,** comprising representatives from the statutory health professions councils, "health public entities, organised labour, civil society organisations, associations of health professionals and providers as well as patient advocacy groups "in such a manner as may be prescribed". This seems to be the only committee with potential representation from labour, civil society and users, but since members are appointed by the minister "in a manner as may be prescribed", it is doubtful whether they will truly represent and be accountable to those constituencies.

We note with concern that none of these advisory committees have **representation from child health** specialists or the children's sector. This raises concerns that children and adolescents specific needs are unlikely to be adequately addressed and prioritised. For example, there is little to no consideration of children in the National Core Standards outside of neonatal and paediatric wards, despite the vulnerability of neonates and children in EMS settings, and adolescents when they move from paediatric to adult services. It is therefore vital that the specific health care needs of children and adolescents are adequately represented on all NHI structures to ensure that both the basket of care and formulary do

justice to children's health care needs.

*5. Concerns around quality, accreditation and inequity*

We note that some measures in the Bill have the potential to exacerbate inequity, including the process for the accreditation of health care facilities and the way user registration will work. The most recent report of the Office of Health Standards Compliance found that **that only five out of the 696 public health facilities surveyed met meet the norms and standards required for certification**.[13] It is important to note that the CSIR have provided norms around the physical structures of healthcare facilities for neonates, children, adolescents and adults, and that these need to be enforced. In addition, we need to establish staffing norms for neonatal, child and adolescent services – as these are likely to require higher staff to patient ratios than adult services.

After more than two decades of public sector austerity, many **public and rural health care facilities are understaffed and under-equipped and unlikely to qualify for NHI accreditation**. Hospitals are more likely to be accredited than clinics and community health centres, with clinics the least likely. Lack of accredited facilities at the community level discriminate against people most dependent on local facilities and increase the hospital centeredness of the health services.

Private facilities are not only more likely to get accreditation but also overwhelmingly urban-based, **thus increasing both urban-rural and private-public inequality**. Furthermore, the fact that the Bill ignores the Certificate of Need[1] contained in the National Health Act represents a key missed opportunity to improve equity. There is a **possibility that some people – particularly children living in rural areas who are the most vulnerable and in need of care - will not have access to NHI-funded health care at all.** While urban and private sector facilities are more likely to get accreditation, leading to increased inequality.

It is therefore concerning **that fewer than 1% of the inspected facilities met the requirements for OHSC certification**. Are all the facilities that failed so bad that they can't deliver their required services safely and effectively? Are the inspection protocols realistic or even appropriate?
For example, the OHSC Annual Inspection Report for 2015/2016 revealed that the Red Cross War Memorial Children's Hospital failed to meet the standards required. Examples of failures included: emergency trolleys that did not have adult oxygen masks (this was categorised as 'Extreme"); procedures for conducting and acting on risk assessment of frail and aged patients were not available, nor had risk assessment been conducted on the files of frail or aged patients (categorised as "vital"). While many of the other listed failures are valid, it seems inappropriate for a children's hospital to be expected to conduct risk assessments on the files of frail or aged patients, and raises concerns around the extent to which the specific needs of children and adolescents are adequately addressed in the national norms and standards.

The **requirements for user registration, which can only be done at accredited facilities is likely to further deepen inequities in access to care**. To apply for registration a person must provide biometrics, fingerprints, proof of residence, ID card, original birth certificate, or refugee ID card. This poses yet another risk that those already marginalised from access to care (e.g. rural populations, children, the disabled or elderly) will be further disadvantaged. Facilities that already lack staff, medicines and equipment will not find it easy to register users as smoothly as those facilities already

[1] The Certificate of Need is designed to regulate where private providers can open services.

functioning at a much higher level of efficiency. Many public sector facilities lack easy **internet access.**

*6. Strengthening primary health care for children and adolescents*

The Bill includes a commitment to strengthening Primary Health Care (PHC) services and views the building of a high quality, effective PHC delivery platform as the foundation of the health system. The Bill emphasises health promotion and disease prevention, and intends to make extensive use of community- and home-based services.

- PHC outreach teams will visit households allocated to them regularly, provide health promotion and education, identify those in need of preventive or rehabilitative services, and refer them to the relevant PHC facility. The outreach teams will also facilitate community involvement and participation in identifying health problems and behaviours and implement interventions to address these problems at a community level.
- School health services will be provided to improve the physical and mental health and general well-being of school going children.
- Private providers will be included to improve capacity & access to care.

However, the Minister of Finance's mid-term budget statement[14] promised ongoing cuts to health budgets with the **only new money to** be made available from Treasury being grants directly to provinces to **contract private providers**. In the face of austerity, it will be hard turn services around after years of neglect and promoting private sector provision will not address the critical needs in child health.

The original plans for primary health care reengineering also outlined the central role of **District Clinical Specialist Teams** (DCSTs) in providing leadership and clinical governance for maternal and child health at district level. It is therefore of concern that there is no longer any reference to the DCSTs in the NHI bill, as this investment in clinical governance is essential to strengthen systems, improve coordination and ensure effective delivery of maternal, child and adolescent health services that are responsive to the local burden of disease. Strong leadership for child health is also needed at provincial level yet only two provinces have appointed provincial paediatricians despite recommendation from the Ministerial Committee on Mortality and Morbidity in Children under five.[15]

Similarly, the original plans to re-engineer **rehabilitation services** at district level should be revived in order to address the needs of large and growing numbers of children with LTHCs and disability – especially in rural areas.[16]

It is also vital that the NHI invests in sufficient numbers of **community health workers**, as well as their education, supervision and support to ensure they are able to play a broader role in supporting families of young children and enabling children to not only survive but thrive -as outlined in the National Integrated ECD Policy and Nurturing Care Framework. Community health workers can also make critical contributions to delivering the combination of provisions needed to address the needs of the most vulnerable adolescents and young people, as outlined in the National Adolescent and Youth Health Policy. Moreover, peer-based models, centred on adolescents and young people becoming trained as community health workers have great potential. It is currently not clear how

community-based services will be funded under NHI and whether there would be prescribed basket of care, as there is a danger that the NHI model and its **efforts to promote efficiency** and a one-size-fits-all approach **might compromise the quality of outreach services,** and fail to recognize the time spent travelling long distances and/or supporting families in difficult circumstances which is much harder to quantify than a simple diagnosis and medication.

*Conclusion*

It is vital that the NHI prioritises child and adolescent health as early and sustained investment – starting in the first 1,000 days and continuing into adolescence – – the first 1,000 weeks – yields the greatest **lifelong** returns. Strong leadership for child and adolescent health is therefore essential at district, provincial and national level. Child and adolescent health needs to be adequately represented on the Benefits Advisory Committee and Stakeholder Advisory Committee to ensure that the unique vulnerabilities and specific health care needs of children and adolescents are explicitly addressed in both the formulary and baskets of care. These efforts should be informed by, and build upon, the framework for an essential package of care developed by the Committee of Morbidity and Mortality of Children under five.

A similar process of engagement is needed with the Office of Health Standards Compliance to ensure that the national norms and standards are aligned with children's rights and best interests. And greater efforts are needed to strengthen systems and drive quality improvement to ensure that clinics and hospitals serving rural and vulnerable children are accredited and able to offer quality care.

---

[1] Constitution of the Republic of South Africa. Act 108 of 1996. Section 28(2)

[2] Laryea-Adjei G & Sadan M (2012) Children and inequality: Closing the gap. In: Hall K, Woolard I, Lake L & Smith C (eds) *South African Child Gauge 2012.* Cape Town: Children's Institute: University of Cape Town.

[3] Hall K. 2015. Housing and Services. *Children Count* website, Children's Institute, UCT. Accessed on 28 April 2016

[4] Shisana O, D Labadarios, T Rehle, L Simbayi, K Zuma, A Dhansay, P Reddy, W Parker, E Hoosain, P Naidoo, C Hongoro, Z Mchiza, NP Steyn, N Dwane, M Makoae, T Maluleke, S Ramlagan, N Zungu, MG Evans, L Jacobs, M Faber and the SANHANES-1 Team (2013) *South African National Health and Nutrition Examination Survey (SANHANES-1)*. Cape Town: HSRC Press

[5] Hall K. 2019. Child health—Children living far from health care facility. *Children Count* website, Children's Institute, University of Cape Town. Accessed on 10 November 2019.

[6] Health Systems Trust (2012) *National Health Care Facilities Baseline Audit: Summary Report*. Durban: HST.

[7] Jan M, I Mafa, K Limwame and A Shabalala. 2012. *Challenges to youths accessing sexual and reproductive health information and services in Southern Africa: A review of qualitative research in seven countries*. A paper presented at the 5th Africa Conference on Sexual Health and Rights, 19 – 22 September 2012. Windhoek: Namibia

[8] Amnesty International (2014) *Struggle for Maternal Health. Barriers to Antenatal Care in South Africa*. Index: AFR 53/007/2014. London: Amnesty International.

[9] Statistics South Africa (2017) *Statistical release P0305. Recorded live births 2017*. Pretoria: Stats SA. Available at: http://www.statssa.gov.za/publications/P0305/P03052017.pdf

[10] Constitution of the Republic of South Africa. Act 108 of 1996. Section 28 1(c)

[11] [11] Department of Health (2011) *1st Triennial Report. Ministerial Committee on Mortality and Morbidity in Children under 5 Years of Age in South Africa*. Pretoria: DoH.

[12] Office of the High Commissioner of Human Rights (1989) *Convention on the Rights of the Child, UN General Assembly resolution 44/25.* Geneva: UN.

[13] Office of Health Standards Compliance (2018) *Annual Inspection Report 2016/17.* Pretoria: OHSC.

[14] http://www.treasury.gov.za/documents/mtbps/2019/mtbps/FullMTBPS.pdf

[15] Department of Health (2011) *1st Triennial Report. Ministerial Committee on Mortality and Morbidity in Children under 5 Years of Age in South Africa*. Pretoria: DoH.

[16] Department of Health (2011) *1st Triennial Report. Ministerial Committee on Mortality and Morbidity in Children under 5 Years of Age in South Africa*. Pretoria: DoH.