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Public Service Accountability Monitor

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SUBMISSION ON THE NATIONAL PUBLIC HEALTH INSTITUTE OF SOUTH AFRICA BILL

SUBMITTED TO THE PORTFOLIO COMMITTEE FOR HEALTH, PARLIAMENT OF SOUTH AFRICA

Submitted by:

The Public Service Accountability Monitor (PSAM)

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THE PUBLIC SERVICE ACCOUNTABILITY MONITOR

The Public Service Accountability Monitor (PSAM) is a civil society organisation that aims to improve the provision of public services essential to the reduction of poverty by strengthening social accountability initiatives. The PSAM is specifically concerned with improving governance and public resource management in South Africa and sub-Saharan Africa.[3] This is achieved through the activities of three interrelated programmes: the Monitoring and Advocacy Programme (MAP), the Regional Learning Programme (RLP) and the Advocacy Impact Programme (AIP). The PSAM was established in 1999 and is based at Rhodes University within the School of Journalism and Media Studies in the Eastern Cape. The Monitoring and Advocacy Programme of the PSAM seeks to contribute to the progressive realisation of the rights to housing, health and education. The programme also focusses on strengthening public accountability mechanisms in the areas of environmental governance and local government.

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[2] Resubmitted on Friday 4th August 2017 with updated content
[3] The PSAM currently has partnerships and country programmes in Zambia, Zimbabwe, Tanzania and Mozambique.

INTRODUCTION:

While the South African government has made advancements in healthcare provisioning over the past twenty-three years, the public health system continues to fail many. Continuous efforts towards the progressive realisation of healthcare are imperative.

The right to healthcare does not relate merely to the right to receive medical treatment, it also requires ongoing, strategic interventions that recognize the impact of structural inequities and social factors that continue to frustrate the struggle to attain universal healthcare. More than increasing *access* to medicines, the South African government also needs to address these wide-ranging social factors. Amongst these are insufficient numbers of primary healthcare clinics in rural areas, lack of antenatal education, inadequate provisioning of electricity, water and sanitation and a lack of sufficiently trained healthcare professionals in rural areas through-out South Africa.[4] Research, data management and public education in relation to health also constitutes a significant gap .

The necessity and value in the establishment of the '**National Public Health Institute of South Africa**' (hereinafter "the Institute" or "NAPHISA") cannot be disputed and is an encouraging recognition of the need for better aligned and coordinated public health institutes prioritising research, disease surveillance and public health intervention.

The Institute's mandate to record and analyse data relating to disease and injury and to provide training and to investigate and conduct research into the main health challenges faced in South Africa is important.

The PSAM therefore hopes that the concerns raised below will assist in strengthening the objectives of the Institute as governed by the **National Public Health Institute of South Africa Bill** (hereinafter "the Bill").

FUNDING OF THE NAPHISA:

Funding and transfer of National Health Laboratory Service (NHLS)

According to Section 29 of the Memorandum on the objectives of the NAPHISA;

> *"The process of amalgamation has already begun with the merger of the NICD and the National Cancer Registry.* ***In addition, funding to create new information and financial management systems has been provided for through the National Treasury during the 2016/17 financial year.*** *This significantly reduces the cost of transition. There are advanced discussions with the Service around shared corporate functions during the transition processes, reducing the need for additional funding that needs to be made available. Lastly,* ***implications on the personnel budget have been reduced due to the decision to align the staff of NAPHISA with the Department of Public Service and Administration's remuneration scales and conditions of service****."*

[4] http://www.samj.org.za/index.php/samj/article/view/6622/4918

The support from the National Treasury is encouraging and is an important indicator of the prioritisation of the NAPHISA by the South African Government. It is recommended, however, that clearer supplementary funding mechanisms are articulated particularly where allocations to the development of data management systems have been sourced to respond within transitional timeframes. Given rapidly changing data management systems and surveillance research needs as well as ICT advances – the Bill could provide for funding in addition to the National Revenue Fund. For instance, the National Health Laboratory Service (NHLS) Research Trust funds the Service's pathology research that is undertaken by students and staff of the departments or schools of pathology in national medical schools.

Amongst the key developments relating to the Institute is the transfer of the National Health Laboratory Service to the NAPHISA. Key programme priorities of the NHLS relate to ensuring that the work of the Service has relevance in the future in addition to providing vital testing services to public health institutions.[5] Recent events relating to protests by NHLS staff raise critical questions about the state of the Service's funding, governance and accountability structures. The excerpt (2nd August 2017) below taken from national media coverage is worth considering;

> "*The NHLS downed tools after the national body said that they could not meet the demands of the workers. the national body could not meet the employees' demands for better benefits which include a housing allowance…In a joint statement by the Treatment Action Campaign and SECTION27 they expressed that they supported the employees of NHLS in their quest for* ***a reasonable salary increase and working conditions****: "****We commend them for exposing corruption and call for an urgent investigation into allegations*** *by Nehawu and others," said SECTION27 and TAC in a media statement.*
> *…* ***the NHLS faces a major debt problem*** *which might see them not being able to pay salaries from November.* ***The main root of the problem lies in the failure of provincial governments to pay their NHLS bills****, with R5-billion outstanding. "There is no sort of commitment from the province, if province doesn't pay NHLS will run out of funds," said Prof Shabir Madhi, NHLS CEO."*
>
> -(emphasis added)[6]

It is recommended that in the process of formulating a new funding structure for the Institute, that the current funding shortfalls and alleged financial maladministration are accounted for as suggested above. Additionally, the Bill must create stronger accountability structures between the Institute/NHLS and provincial government departments. This could be catered for within the reporting requirements of the Chief Financial Officer to the Minister and of the Minister before the relevant parliamentary committee.

FUNCTIONS OF THE NAPHISA:

Data systems and technical support

Section 3 (1) states the Institute must;

> *"b) coordinate, develop and* ***maintain surveillance systems*** *to collect, analyse and interpret public and occupational health data in order to guide health interventions;*

[5] The National Health Laboratory Service: http://www.nhls.ac.za/?page=priority_areas&id=11
[6] https://www.dailymaverick.co.za/article/2017-08-02-talks-continue-as-health-lab-strike-suspended/#.WYLT04iGNEY

> *c**) use surveillance data and other sources of information**, where appropriate, to advise on the setting of health policies, priorities and planning;*
>
> *m) collaborate with relevant government departments and government agencies to **implement communication strategies on public and occupational health issues and outbreak response**;*
>
> *n) **provide technical support to all spheres of government and other regulatory bodies on surveillance** of communicable diseases, non-communicable diseases, cancer, injury and violence prevention and occupational health and mitigation strategies for occupational exposure and*
>
> *o) coordinate research and, where appropriate, conduct research to inform policy and guidelines on communicable diseases, non-communicable diseases, cancer surveillance, injury and violence prevention and occupational health, and **must develop processes for dissemination of research findings to key stakeholders"*** (emphasis added)

The emphasis on data systems, their maintenance as well as processes for data dissemination and management is significant. There is an inadequate coverage or recognition within the Institute's proposed functions and roles of the specific mechanisms that will be used to facilitate the coordination, dissemination, research and disease surveillance work in alignment, for instance, with the South African government's open data[7] commitments.[8] The Bill does not adequately address modern data considerations – particularly in relation to information and communication and technology (ICT) needs and management of vast national public health and disease surveillance trends.

In particular – the maintenance of surveillance data systems as well as monitoring systems (at the core of the Institute's activities) should be connected to modern ICT systems and – where possible – the governance structures of the Institute should reflect this. The use of modern open access, open data systems can result in significant cost savings and enhance citizen awareness.

Important research that can – and should – be made available on public platforms can be effectively disseminated to assist with wider awareness and advocacy. While the Bill outlines this as a priority – there isn't an explicit commitment to providing public access to such research on

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[7] Verhulst *et al.* (2014) define open data as data that is available to the public, that can be readily used and accessed and disseminated free of charge
Verhulst, S., Noveck, B.S., Caplan, R., Brown, K. and Paz, C. 2014. *The Open Data Era in Health and Social Care: A Blueprint for the National Health Service (NHS England) to Develop a Research and Learning Programme for the Open Data in Health and Social Care*. The Governance Lab (GOVLAB) NYU.

[8] The South African government is a founding member of the Open Government Partnership (OGP) –an international, multilateral initiative with the objective of securing concrete commitments from governments to "promote transparency, empower citizens, fight corruption, and harness new technologies to strengthen governance". Amongst the objective of the OGP is to ensure citizen access to government data for accountable and improved service delivery on areas such as education and health. Further information about the OGP is available on the OGP South Africa site: http://www.ogp.gov.za/

modern, for instance, open data portals.[9] This would have important possibilities for providing health practitioners, scientists and members of civil society with scientifically sound, unbiased research for informed policy development and decision making.

At the very least – it would be of value for the Bill to create the room for such innovation within the formulation of the Institute's functions. The potential benefits for improved health services are worth considering as Verhlust *et al.* (2014:10) contend in a discussion reflecting on this in the context of the National Health Service (NHS) in England;

> "*Today, the potential of open health data is widely recognized. Researchers, journalists and of course healthcare providers celebrate an* ***opportunity to improve efficiency of service delivery, catalyze provider accountability, and help patients make more informed choices about their care****.*
>
> *… as the NHS moves to release data systematically, it needs to put in place a strategy for measuring the value of open data for the various stakeholders involved in the nation's healthcare system—and, indeed, for citizens in general.* ***In today's budgetary climate, it is not enough to assess the value of expensive and complicated government programmes after the fact****. We need to enhance our ability to marshal an arsenal of evidence in order to protect investments in innovative and potentially important new programmes.* ***By becoming more agile in how we measure innovations in governance like open data, we can make government more efficient, and more effective****."*

The use of technologies such as open data portals and related innovation would also facilitate real-time disease outbreak information and related alerts with greater efficiency and with a wider reach. In particular – mobile alert technology would be beneficial for rural communities for whom access to social media and the internet is limited. As a very important step in recognition of the need to engage the public and include a wider range of actors in decision making around public health data – the Bill should, within its governance structures incorporate such expertise possibly through the inclusion of an ICT or open data expert.

Environmental and Occupational Health

Public health is not confined to competencies of medical/health practitioners nor to the Department of Health. 'Health' is therefore multi-sectoral and multi-dimensional. The South African Constitution also provides various guiding frameworks for the provisioning and promotion of a clean, safe and healthy environment. Within it are entrenched substantive environmental rights. Section 24 in Chapter two of the South African Bill of Rights states that everyone has the right;

a) to an environment that ***is not harmful to their health or well-being****; and*
b) to have the environment protected, for the benefit of present and future generations, through reasonable legislative and other measures that –

i. ***prevent pollution and ecological degradation****;*
ii. promote conservation; and

[9] The South African OGP commitment have a focus, through the Department of Public Service Administration, for instance, on the creation of an open data portal through which information on government activities and decisions can be made accessible, open, comprehensive and freely available to the public.

iii. secure ecologically sustainable development and use of natural resources while promoting justifiable economic and social development.

(emphasis added)[10]

Section 24(a) provides for protection of the environment towards ensuring the health and well-being of individuals, while section 24(b) concern the forward-looking nature of the right to environment, which has important implications for the management of natural resources.

Additionally; the National Environmental Health Policy of 2013 which is aligned to the National Development Plan and is intended to serve as a framework within which South African Environmental Health Services should be provided for within this Act. A key component of this framework is the inclusion of monitoring and evaluation responsibilities in the implementation of activities defined within the realm of environmental health services. This, according to the policy, includes the assessment of environmental risks and hazards including waste management, pollution control and water quality control. The policy also aims to give effect to the Libreville Declaration of 2008 and promote intergovernmental promotion for the implementation of its goals. Furthermore, Section 1 of the policy takes cognizance of the significant contribution of avoidable environmental factors to the country's quadruple burden of disease.[11] The policy also emphasizes the need to address important health determinants and the distinct needs special population groups such as women and children.

The current NAPHISA Bill does not adequately consider the provisions of Section 24 of the Constitution nor of the above-mentioned policy. This could potentially translate to significant gaps in relation to research, monitoring and overall policy coordination within the Institute and between the Institute and other government departments.

However, we note and are encouraged by the proposed governance structures as discussed below which also accounts for experts within the field of environmental health. This is an important inclusion.

ACCOUNTABILITY AND GOVERNANCE STRUCTURES:

Public representation on the Board

The Act provides for the composition of the Board of the NAPHISA. Members of the Board will be appointed by the Minister of Health.
These will include;

I. An official from the national Department of Health;

II. two members who have special knowledge in economics, financial matters or accounting; and legal matters;

seven members comprising one member each with special knowledge in;

III. communicable diseases;

IV. non-communicable diseases;

[10]Constitution of the Republic of South Africa, 1996

[11] This includes the World Health Organisation estimation that across the African continent, 70% of child deaths are attributed to environmental risk factors.

V. *cancer surveillance;*

VI. *injury and violence prevention;*

VII. *occupational health;*

VIII. *field epidemiology; and*

IX. *environmental health;*

X. ***one community representative****;*

XI. *the Chief Financial Officer of the NAPHISA by virtue of his or her office;*

XII. *the Chief Executive Officer of the NAPHISA by virtue of his or her office; and*

XIII. *one member nominated by the schools of public health within publicly funded higher education institutions*

(emphasis added)

While the Bill clearly recognises the importance of the representation of a range of skilled professionals on the governing Board – there is an under representation of members of the public and of health-promoting civil society organisations. There is no stipulation of the requirements or eligibility for the single "community representative".

There is also significant under representation of ICT expertise despite a heavy emphasis in this within the outlined functions and activities of the Institute.

It is also unclear what the geographical representation on the Board would be given the widely varied provincial contexts where public health and disease surveillance. This is important when one reflects on the complexities of structural inequities and the provincial variations in relation to the social determinants of health.

There is a clear need for the Bill to provide more opportunities for members of the public to contribute to the NAPHISA. This could be achieved through the inclusion of at least two members of the public, at least one ICT expert – possibly a civic technology expert and at least one member of civil society with a proven track record in health activism, research and community mobilisation.

It is also advisable for the Bill to outline some basic eligibility criteria of the community members on the panel in order to ensure greater representation of marginalised groups and those advocating for the rights of women and children in particular.[12] It may be of benefit to stipulate that the public representatives must have a clear track record of community engagement.

Section 4 of the Bill states that the board is the accounting authority of the NAPHISA, and that the CEO is the administrative head as well as a board member.[13]

[12] These objectives are mirrored in the priority programmes of the National Health Laboratory Services
[13] B16-2007

The recommendation in this respect that an oversight body be created in order to supervise expenditure within the Institute and to provide disciplinary proceedings if funds are spent in a way inconsistent with the Act.

Reporting and Accountability Mechanisms

Section 3(1)(w) requires that the Institute;

> *"produce and distribute reports on health and disease profiles, injuries and violence and occupational health".*[14]

It is recommended that the Bill require that these reports be produced according to the specific divisions and distributed on public platforms on regularly - at least quarterly, in order to achieve the objective of surveillance. It would also be helpful if the Act provide specific sub-headings in terms of what information these reports would contain. These sub-headings should be determined in consultation with each division.

Section 3(l)(l) mentions that the NAPHISA must;

> *"support the health sector response and make recommendations to government on*
>
> *(i) control measures for disease outbreaks; and*
>
> *(ii) mitigating risks and hazards of injury and violence, cancer and workplace exposures"*

There is no mention of whether these recommendations are of a binding nature or how the National Department of Health should implement such the recommendations and –whether any obligations are placed on the relevant Department to implement, consider or explain non-implementation of same recommendations. A clearer articulation of this section is especially important given the relatively high cost at which the scientific research informing the findings and recommendations made by the Institute. It would also be of benefit for strengthening horizontal accountability within and between government department and the Institute.

CONCLUSION:

The NAPHISA Bill constitutes an important step towards meeting its objectives of ensuring the promotion of the progressive realization of right to health care. The PSAM is encouraged and supportive of the developments of the NAPHISA to date and looks forward to supporting the strengthening of the Bill.

[14] B16-2007