# NATIONAL ASSEMBLY

**FOR WRITTEN REPLY**

**QUESTION NO. 1332**

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**(INTERNAL QUESTION PAPER NO. 13)**

**Mrs M O Clarke (DA) to ask the Minister of Health:**

(1) What (a) is the total amount budgeted for National Health Insurance (NHI) grants annually since 2017, (b) amount of each grant was spent, (c) items was the specified amount spent on and (d) amount was returned to the National Treasury;

(2) Regarding the NHI pilot projects what (a) amount was budgeted for each project, (b) is the breakdown of each project and (c) amount has been spent annually on each project since they were launched,

(3) what were the (a) outcomes of each NHI project;

(4) whether the outcomes were successfully achieved; if not, why not; if so, (a) how were they evaluated and (b) what are the further relevant details? **NW1534E**

**REPLY:**

1. The following grants have been established:
2. NHI Schedule 5 Direct Grant
3. NHI Schedule 6 Indirect Grant which consists of:
* Health Facility Revitalisation Component (In Kind Grant)
* Personal services component
* Non-personal services component

(a)-(b) The overall budget and expenditure of the NHI Grant has been as follows:





For the 2017/18 and 2018/19 financial years, it was only the NHI Indirect grant allocation and from 2019/20 it was funded from both direct and indirect grant allocations as follows:



(c) The items that the specified amount were spent on and (d) the amount returned to the National Treasury are as follows:



1. (a) NHI Pilot Projects were conducted from 2012/13 to 2015/16. The breakdown of the amounts that were budget for during this period are outlined in the Table below:

|  |  |
| --- | --- |
| **National Health Insurance Direct Grant**  |   |
|  | **2012/13** | **2013/14** | **2014/15** | **2015/16** | **2016/17** | **Total** |
| NHI Direct Grant  | 150000,000 | 48000,000 | 72000,000 | 72000,000 |   | 342000 |
| Eastern Cape  | 11,500 | 4,850 | 7,000 | 7,204 |   | 30,554 |
| Free State | 11,500 | 4,850 | 7,000 | 7,204 |   | 30,554 |
| Gauteng  | 31,500 | 4,850 | 7,000 | 7,204 |   | 50,554 |
| KwaZulu-Natal  | 33,000 | 9,700 | 14,000 | 14,408 |   | 71,108 |
| Limpopo | 11,500 | 4,850 | 7,000 | 7,204 |   | 30,554 |
| Mpumalanga | 11,500 | 4,850 | 7,000 | 7,204 |   | 30,554 |
| Northern Cape | 11,500 | 4,850 | 7,000 | 7,204 |   | 30,554 |
| North West  | 11,500 | 4,850 | 7,000 | 7,204 |   | 30,554 |
| Western Cape | 11,500 | 4,850 | 7,000 | 7,204 |   | 30,554 |

(b) The breakdown of the projects that were funded through the direct NHI Conditional Grant were as follows:

The NHI project was undertaken in 11 pilot districts across the country namely:

1. OR Tambo (Eastern Cape)
2. Thabo Mofutsanyana (Free State)
3. City of Tshwane (Gauteng)
4. Amajuba District (KwaZulu-Natal)
5. Umzinyathi (KwaZulu-Natal)
6. uMgungundlovu (KwaZulu-Natal)
7. Vhembe (Limpopo)
8. Gert Sibande (Mpumalanga)
9. Dr Kenneth Kaunda (North West)
10. Pixley ka Seme (Northern Cape)
11. Eden (Western Cape)

The following interventions were undertaken in the aforesaid pilot districts:

1. Ward-based Primary Healthcare Outreach Teams (WBPHCOTs), which were responsible for the provision of promotive and preventative healthcare to households;
2. the Integrated School Health Programme (ISHP), which aimed to provide a range of health promotion and preventive services to school-going children at their places of learning;
3. General Practitioner (GP) contracting, which aimed to increase the number of GPs at PHC facilities to improve the quality and acceptability of care;
4. the Ideal Clinic Realisation and Maintenance (ICRM) model, which aimed to increase the quality of services through the establishment of minimum standards;
5. District Clinical Specialist Teams (DCSTs), which were responsible for supporting clinical governance and undertaking clinical work, research and training;
6. The Centralised Chronic Medicine Dispensing and Distribution (CCMDD) system, which aimed to improve the distribution of medicines to patients through the provision of chronic medication at designated pick-up points (PUPs) closer to the communities in the pilot districts;
7. The Health Patient Registration System (HPRS), which has the ultimate goal of a fully electronic patient record-keeping system but commenced with the capturing of patient data and the generation of electronic files;
8. The Stock Visibility System (SVS), which aimed to improve the oversight of stock through an electronic stock monitoring system, thereby reducing stockouts by allowing for appropriate and timely ordering;
9. Infrastructure projects, which were implemented to improve health infrastructure and thereby ensure increased access and quality of care;
10. Workload Indicator for Staffing Need (WISN), which are a World Health Organization (WHO) planning tool implemented to help facility managers make more efficient staffing decisions.

(3) (a)Some of the core outcomes of the project are outlined below per district:

**Amajuba (KwaZulu-Natal)**: This district recorded a mixed set of results when it comes to key indicators that were being tracked as part of the NHI interventions – antenatal first visit before 20 weeks and HIV positive on IPT. There was a noticeable improvement in 2015, then followed by a decrease in both indictors over 2016 and 2017.

**uMzinyathi (KwaZulu-Natal)**: There was a marked improvement in the immunization rate for children under the age of one, with a further indication that directed efforts needed to be implemented to prioritize mother and child health interventions;

**uMgungundlovu (KwaZulu-Natal):** The district has recorded an improvement in the immunization rate, specifically for the uptake of the measles second dose. However, indicators also pointed to the need to improve the roll-out and capacity of the Ward-Based Outreach Teams.

**OR Tambo (Eastern Cape)**: As a result of various interventions, the district recorded a year-on-year improvement in cervical cancer screening for women over 30. This improvement also showed a marked increase in the ranking of the district as compared to other pilot and non-pilot districts. The same can be reported Diarrhea with dehydration under five.

**Gert Sibande (Mpumalanga):** This district recorded the highest rate of improvement in immunization uptake for those under five for all the pilot districts. This was specifically for the 2016 to 2017 period. The main challenge they experienced was around having well-capacitated Ward-Based Outreach Teams, and the ability to recruit and retain adequately skilled team members.

**Vhembe (Limpopo)**: The district recorded an improvement in the reported number of cases with diarrhea and dehydration under five. Vhembe showed a sharp decrease in performance for this indicator. The qualitative information revealed a lack of functional DCSTs, with speculation that they need to be dismantled and a new solution found. This is potentially problematic because, with poor immunization coverage, there is a higher risk for poor child health. The DCSTs will then be critical to ensuring that child mortality does not increase.

**Dr Kenneth Kaunda (North West):** The district also recorded a year-on-year improvement in cervical cancer screening for women over 30. This improvement also showed a marked increase in the ranking of the district as compared to other pilot and non-pilot districts. It ranked second only to OR Tambo District.

**Eden (Western Cape)**: A key achievement for the district was that it consistently reported the lowest levels of drug stock-outs amongst all the pilot districts.

**Thabo Mofutsanyana (Free State):** The district recorded a significant improvement in the number of diarrheal cases with dehydration over the period 2013 to 2017. They also achieved significant improvements in the number of school learners screened for eyesight, hearing and related conditions.

**Pixley ka Seme (Northern Cape)**: The district recorded significant improvements and was consistently the lowest performer among the NHI pilot districts for the HIV positive with IPT and the BCG dose coverage indicators respectively.

**City of Tshwane (Gauteng)**: This district was amongst the lowest performers of the districts included in the NHI project for the indicator on Antenatal visit before 20 weeks. However, it still recorded significant improvements in the indicator on diarrheal cases with dehydration over the period 2013 to 2017.

More generally, it must be noted that majority of the NHI districts recorded significant achievements in the establishment and roll-out of the Ward-Based Primary Health Care Outreach Teams (WBPHCOTs). The WBPHCOT intervention is currently underpinned by the Policy Framework and Strategy for Ward-based Primary Healthcare Outreach Teams 2018/2019 – 2023/2024 and aims to ensure the successful implementation of the teams and the overall success of NHI implementation in South Africa. As far back as September 2017, a reported 3,519 WBPHCOTs were covering 12 816 152 households. At the end of 2017/2018 financial year, there were a total of 3,323 WBPHCOTs providing basic health services to children and adults across the country, not just in the NHI districts.

(4) (a)-(b) The evaluation of the various interventions implemented as part of NHI is based on a number of interrelated processes, including regular monitoring and evaluation of progress through the Annual Performance Plans at the National and Provincial Departments of Health. It also included undertaking a rigorous evaluation exercises and the prepartion of technical reports detailing the various interventions implemented over time and the impact that these selected interventions have had on key indicators such as antenatal visits, incidence of diarrhea cases as well as establsihment of key teams such as PHC outreach teams. The Evaluation Report is attached as Annexure 1. The implementation of various interventions resulted in a number of interellated achievements, some of which include:

1. The successful roll-out of the Ward-Based Primary Health Care Outreach Teams (WBPHCOTs) intervention aimed at ensuring the successful implementation of the PHC teams and the overall success of NHI implementation in South Africa. As far back as September 2017, a reported 3,519 WBPHCOTs were covering 12 816 152 households. At the end of 2017/2018 financial year, there were a total of 3,323 WBPHCOTs providing basic health services to children and adults across the country, not just in the NHI districts.
2. The rollout of the Integrated School Health Programme (ISHP). The aim of the ISHP intervention is to provide a range of health promotion and preventive services to school-going children with a particular focus on the screening of health-related barriers to learning such as vision, hearing, cognitive and related developmental impairments (National Department of Health, 2017). The programme is underpinned by the Integrated School Health Policy, which outlines the complementary roles of each government department responsible for addressing the needs of learners with the aim of ensuring that strong school health services operate according to clear and uniform standards across the country (National Department of Health, 2013). This intervention was implemented by the NDoH in collaboration with the DBE and holds important lessons with regard to inter-departmental collaboration and coordination during implementation. National stakeholders expressed the belief that, overall, there was good collaboration between the national departments in implementing ISHP.
3. Contracting of Health Practitioners (“GP Contracting”): Recognising that Human Resources for Health (HRH) are a key component of a well-functioning health system, and that the inequitable distribution of human resources within the dual health system in South Africa has been an ongoing challenge. Historically, GPs have not been part of the staffing composition at public PHC facilities. Furthermore, the lack of GPs in the public sector has impacted the system in a number of ways. Notably, this has impacted patients’ perceptions of the quality of care received at PHC facilities. This intervention was implemented to improve quality of care and access to needed health care services at the local facility level, especially in targeted clinics through the introduction of different contracting mechanisms with the aim of improving access and quality services to vulnerable communities.

The contracting of GPs was introduced in 2012 as part of NHI Phase 1 implementation, and at the end of 2017/2018, 330 GPs had been contracted. GP contracting was identified by stakeholders as one of the most important interventions to ensure health system strengthening (HSS). The intended aims and objectives of contracting GPs are evidently clear and well understood among stakeholders. The key objectives of GP contracting were to reduce the over-utilisation of hospitals and to improve quality of care (and perceptions thereof) of public healthcare facilities.

1. Ideal Clinic Realisation and Maintenace (ICRM):ICRM was introduced in response to existing insufficiencies in the quality of PHC services and to lay the foundation for NHI implementation. This intervention was introduced in South African facilities in July 2013 with the aim of improving quality of care after a baseline audit commissioned by the NDoH in 2011 discovered that only one facility in the country met the required standards of a health facility. An ideal clinic is defined as a clinic with good infrastructure, adequate staff, adequate medicine and supplies, good administrative processes and sufficient adequate bulk supplies. It uses appropriate clinical policies, protocols and guidelines, and it harnesses partner and stakeholder support to ensure the provision of quality health services at PHC level to communities. There are 10 components of the ICRM programme, all of which contain subcomponents that specify the initiatives under each component.

The evaluation findings suggest that ICRM is an intervention that achieved considerable scale and reach during NHI Phase 1. At the end of 2017/2018, 3 434 facilities had been assessed, and of these, 1 507 had attained ideal clinic status. Of the facility managers surveyed, 51 of 60 (86%) reported that ICRM was being implemented in their facility.

Moreover, the intervention is commonly understood to have significantly contributed to HSS over the previous five years of implementation as a result of its initial large scale-up across the country.

1. Establishment of District Clinical Specialist Teams (DCSTs): The DCSTs were envisioned to comprise highly specialised HCPs, including an obstetrician and gynaecologist, a paediatrician, a family physician, an anaesthetist, a midwife and a professional nurse, and it was expected that they would spend 70% of their time supporting clinical governance, 20% on clinical work and 10% on research and training. Clinical governance encompasses the maintenance and improvement of standards for patient care at facilities. The various activities of clinical governance have been implemented to different extents in PHC facilities. The four major components of clinical governance are role identification, improving care, improving patients’ experiences and identifying good practice. The DCSTs are responsible for driving these components of clinical governance at district level and are an extension of the district management team and report directly to the district manager as well as the provincial DCST coordinator.
2. Centralised Chronic Medication Dispensing and Distribution (CCMDD): This is a unique model of medicine dispensing and distribution that has been adopted in South, which is led and implemented by the NDoH. CCMDD was introduced in 2012 to improve the successful distribution of medication to patients. This intervention is made up of two components: CCMDD and Pick-Up Points (PUPs); These two components were envisioned (a) to improve the quality of care of patients as chronic patients will be accessing their medication from a private service provider rather than going into facilities, thus decreasing congestion at facilities, making more staff time available and improving the staff’s ability to provide quality services and (b) to increase access for patients and decrease patient waiting times as there will be no need for patients to go to pick up their medication at congested facilities. During the implementation of NHI Phase 1, CCMDD was heavily focused on the provision of antiretrovirals, fixed-dose combinations in particular, to stable HIV patients receiving antiretroviral treatment (ART).

The evaluation findings suggest that CCMDD is overwhelmingly believed to be the NDoH’s most successful intervention implemented during NHI Phase 1. This has been identified as a flagship programme, and for this reason, there are numerous valuable lessons to be learned from its implementation. These lessons will only apply to the continuation of the CCMDD programme but can be useful for the continued implementation of other interventions.

Specifically, lessons around the issues of contracting private service providers, which has been communicated by the NDoH to be a key component of NHI Phase 2. At the end of 2017/2018, there were 2 182 422 patients enrolled in the CCMDD programme who were collecting their medicines from over 855 PUPs across the country (National Department of Health, 2018). On balance, it is evident that CCMDD has indeed achieved its immediate aims of decongesting facilities, which helps improve the availability of HCPs’ time and, as a result, improve health outcomes. The success is largely reflected in the successful scale-up of the programme beyond the pilot districts and beyond the expectations of NHI Phase 1 implementation plans.

1. e-Health interventions:e-Health interventions are those that employ digital solutions to assist health workers and PHC facilities to operate more efficiently, with the ultimate aim of contributing to improved access to and improved quality healthcare.
2. As part of the preparatory work for the phased implementation of NHI, the Department has successfully rolled-out the Health Patient Registration System (HPRS). The HPRS serves as an online registry of all patients using healthcare services in South Africa that can be accessed at any facility to provide health workers with patients’ demographic information and their most up-to-date health records. Patients are registered with a unique identification number (for example, their national identity number or passport number) and assigned to a host facility, which is the facility that they attend most frequently. The HPRS is thus the entry point for patients into the formal health system. The HPRS is expected to lead to more efficient patient registration and record-keeping, which is in turn expected to contribute to better decision-making, to facilitate easier access to patient data and to lead to a better referral system. Overall, the implementation of the HPRS during NHI Phase 1 can be understood to have presented both successes and challenges. At the end of 2017/2018, 2968 PHC facilities were using the HPRS, and there were 20 million people registered on the system (National Department of Health, 2018). Moreover, IT hardware for an additional 918 PHC facilities in 13 health districts was purchased, totalling 4862 computers in total (National Department of Health, 2018). However, challenges have hindered the intervention’s ability to contribute to improved decision-making and referrals thus far. It should be noted, however, that the first stage of implementation was focused largely on setting up user profiles and is not expected to contribute greatly to decision-making as yet. As the implementation of NHI continues and the HPRS becomes more widely used, it will need to be further populated with routine and referral information to improve patient tracking and, in turn, contribute to improved decision-making.
3. Another intervention in the e-Health space is MomConnect.MomConnect is an SMS-based initiative that “aims to support maternal health through the use of cell phone-based technologies integrated into maternal and child health services” (National Department of Health, 2018). The purpose of MomConnect is ultimately to prevent maternal and child deaths through targeted health promotion messages to pregnant women to improve their health and that of their infants (National Department of Health, 2018). At the end of 2017/2018, the number of pregnant women and mothers registered on MomConnect was 1 888 918, which had doubled from the previous financial year. Moreover, a total of 818 688 pregnant women and mothers were receiving health-promotion messages at the end of 2017/2018.
4. There is also the Stock Visibility System (SVS)which is an application designed to address the challenge of drug and related stock-outs and ensure that all South Africans have access to the medicines they need. It is a mobile application used in PHC clinics to monitor and report on stock availability levels for essential medicines like anti-retrovirals, TB medication and vaccines. The purpose of the SVS is to enable more informed decision-making and proactive stock management at PHC facility level. Using the SVS application, clinic staff are able to capture information on the availability of essential medicines at PHC facilities, which is then uploaded to a central online repository. The data from this repository is consolidated in real time to improve oversight of stock availability and, consequently, improve the accuracy and efficiency of stock distribution based on demand.

The SVS is able to detect reported stock-outs at clinic level and automatically send early warning alerts to managers at each point in the supply chain when stock-outs are predicted, from clinic through to national level. In a similar vein, the system also alerts managers to over-stocking, which is necessary to avoid situations where stock is lost due to expiry. These types of alerts thus enable managers to more proactively manage stock levels and avoid stock-outs as well as stock losses. At the end of 2017/2018, the SVS was being implemented in 3167 clinics and CHCs, which equated to 92% coverage (National Department of Health, 2018). The findings of the evaluation indicate that, where it has been implemented as planned, the implementation of the SVS has largely been a success, leading to a reduction in stock-outs and pressure at facilities where it was being implemented.

Over and above all these targeted interventions, the National and Provincial Departments of Health continue to implement a number of interventions directed at maintaining existing infrastructure (clinics, hospitals, CHCs, etc.); refurbishments as well as the commissioning of new ones to address quality and related challenges. Poor infrastructure limits the extent of health services that can be provided to communities. Therefore, since the 2013/14 financial year, more than R1.9 billion has been spent on infrastructure projects in the NHI pilot districts.

END.