# NATIONAL ASSEMBLY

**FOR WRITTEN REPLY**

**QUESTION NO. 1677**

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**(INTERNAL QUESTION PAPER NO. 32)**

**Ms H Ismael (DA) to ask the Minister of Health:**

(1) Whether, with reference to his reply to question 137 on 14 October 2019, he will furnish Ms H Ismael with a detailed report of all National Health Insurance pilot projects, including the name of facilities;

(2) whether any of the pilot projects have failed; if so, what (a) are the names of the pilot projects that have failed and (b) has he found to be the reasons that the projects failed?

 **NW3072E**

###### REPLY:

(1) A copy of the independent report “*Evaluation of the Phase 1 Implementation of the Interventions in the National Health Insurance Pilot Districts in South Africa. NDOH10/2017-2018. Final Evaluation Report. August 2019”* is attached to this response as **Annexure 1.**

(2) (a) No specific facilities that have failed were identified in the report.

Overall, the implementation of the pilot interventions had mixed success across the pilot districts. None of the interventions can be considered “failures”, as all were implemented at scale.

Where successful, a few common factors were identified:

1. Strong political will;
2. Adequate human and financial resources for implementation;
3. Good coordination and communication; and
4. Good monitoring systems put in place at the time of implementation.

(b) The interventions also faced a number of challenges, and, to varying degrees, these factors hindered their success:

1. Inadequate planning;
2. Lack of resources;
3. Inconsistent communication;
4. A lack of coordination where necessary; and
5. Insufficient mechanisms to monitor progress to ensure course correction.

Reports regarding specific projects are contained in the Report and are summarized as follows:

1. **Ward-based Primary Healthcare Community Outreach Teams (WBPHCOTS)**
2. A total of 3 323 WBPHCOTs providing basic health services to children and adults were in place at the end of 2017/18.
3. These teams were able to successfully fulfil their mandate to provide outreach health services within the community.
4. WBPHCOTs completed community visits and were also able to report on the health status of the individuals at the households visited.
5. Teams often lacked the envisioned team composition, with many teams lacking outreach team leaders.
6. Data collection was insufficient to adequately monitor the effectiveness of the referral systems and follow up processes.
7. At times there were insufficient funds for transport and equipment; this impacted the team’s ability to successfully undertake their work.
8. **Integrated School Health Program (ISHP)**
9. A total of 4 339 875 learners had been screened through ISHP since 2012; of these 504 803 were identified to have various health barriers and referred for treatment.
10. The ISHP intervention was particularly successful in its ability to demonstrate good inter-departmental collaboration between the NDoH and Department of Basic Education (DBE).
11. There was a lack of data to support the effectiveness of the referrals and a lack of feedback mechanisms between school teams and facilities.
12. The lack of sufficient equipment, such as measurement scales and transport to travel to schools, often impacted negatively on the success of this intervention.
13. There was a lack of prioritisation and targeting of learners within this intervention.
14. **Human Papillomavirus (HPV) vaccination** campaign as part of the ISHP was launched in 2014. Of 2,289,699 girls in Grade 4, 1,934,635 received HPV vaccines.
15. **General Practitioners (GPs) Contracting**
16. A total of 330 General Practitioners (GP) had been contracted by end of 2017/2018.
17. Where contracting of GPs was implemented successfully, the access to doctors improved at PHC facilities. Patients also perceived that the quality of care improved at facilities due to the presence of GPs.
18. Inadequate monitoring of contracted GPs caused some challenges during implementation.
19. Unforeseen challenges including negotiations that were outside of the DPSA rates as well as inadequate monitoring of contracts resulted in GPs claiming substantially higher expenses than budgeted for.
20. **Ideal Clinic Realisation Model (ICRM)**
21. A total of 3434 facilities had been assessed of which 1507 had attained ideal clinic status at end of 2017/2018.
22. This project is deemed to have improved the ability of facilities to procure much needed equipment.
23. Where the ICRM was believed to have been implemented as planned, there was a perceived improvement in quality of care by both facility managers and patients.
24. One of the challenges identified was that ICRM limited flexibility and the ability for managers to adapt facilities to the local context and to the needs of the facilities at the time.
25. The changing manual and frequent change of standards in the ICRM made it difficult for managers to keep up with the changes and resulted in managers experiencing frustration.
26. **District Clinical Specialist Teams (DCST)**
27. At the end of March 2017, 45 of 52 districts in nine provinces had functional DCSTs with at least three members per team to provide specialist oversight within the districts.
28. The introduction of these teams was perceived by some stakeholders to have promoted clinical governance within the districts.
29. The team composition, which often lacked critical specialists, limited their ability to provide the envisioned training and support structures.
30. The lack of gynaecologist and paediatricians meant that DCSTs were not able to adequately improve child and maternal health as envisioned.
31. Not all specialists were seen necessarily as good mentors and they may have been unable to provide adequate support.
32. The DCST model was assessed to be a costly model and it stretched the limited specialist resources in the public sector.
33. **Centralised Chronic Medicine Dispensing and Distribution (CCMDD)**
34. A total of 2 182 422 patients enrolled on the CCMDD, collecting medicines in over 855 pick-up points (PUPs) at the end of 2017/2018.
35. The strong political leadership and will behind CCMDD contributed towards its successful implementation.
36. CCMDD was scaled up beyond target and the consistent monitoring of the programme contributed to the availability of reliable data to support continued implementation.
37. Changes of service providers threatened the intervention’s continuity.
38. The lack of sufficient integration between CCMDD pick-up points and facilities resulted in inadequate tracking of patients between the two systems.
39. **Health Patient Registration System (HPRS)**
40. At the end of 2017/2018, 2968 PHC facilities were using HPRS and there were over 20 million (20 700 149) people registered on the system.
41. Good communication and feedback loops are seen to have facilitated implementation success.
42. The poor connectivity at some facilities and challenges with hardware have contributed to the challenges experienced during NHI phase 1 implementation.
43. The lack of human resources and lack of capacity in some districts to implement affected the success of HPRS
44. **Stock Visibility System SVS**
45. At the end of 2017/2018, SVS was being implemented in 3167 clinics and community health centres (92% coverage).
46. The successful training of available staff led to an in-depth understanding of the system at facility level. The introduction of SVS led to reduced stock outs and improved efficiency at facilities.
47. The lack of reliable internet connectivity and hardware in some districts , impacted its success.
48. The minimal number of available pharmacists and pharmacy assistants limited facilities ability to ensure the smooth running of the system.
49. The sustainability of this intervention poses a challenge as implementation during NHI phase1 relied heavily on the support from external funders.
50. **Infrastructure**
51. Since 2013/2014, work in 139 of 140 identified CHCs and clinics has been completed through the NHI rehabilitation projects.
52. In 2017/2018 alone, 107 facilities were maintained, repaired and/or refurbished in NHI districts.
53. Where completed, patients perceived an improvement in the quality of care as a result. Small infrastructure changes had a positive impact on the overall environment at facilities.
54. Projects were rarely implemented or completed due to the lack of planning capacity to release the assigned funds.
55. Funds which were released were used mainly for new infrastructure projects
56. However, insufficient attention was paid to the maintenance of facilities, which is critical to both access and the provision of quality services and preventing unnecessary new-build costs due to deterioration because of a lack of basic maintenance.
57. **Human Resources for Health**
58. The introduction of Workload Indicators of Staffing Need (WISN) provided a standardised, evidence-based staffing needs assessment at facility level. These assessments were implemented widely across the pilot districts.
59. The resource constrained environment meant that hiring of staff had been frozen and as a result the WISN findings were not always implementable and caused further frustration among facility managers who had done the assessment.

END.