Dear all - see below the PMG minutes of the presentation of the MoH at the Parliamentary Portfolio Committee on health. Note questions and answers on NHI, the "new" MCC, centralisation of procurement, private sector costs, expensive equipment and contracting in of private sector (incl HCP leaving public for private sector) (presentation in our DoH Dropbox):

Preparations for National Health Insurance (NHI) pilot districts: briefing by Minister of Health

Date of Meeting:
26 Feb 2014

Chairperson:
Mr B Goqwana (ANC)

Documents handed out:
Presentation: Preparation for the National Health Insurance (NHI) Pilot Districts, Department of Health

Audio recording of the meeting:
PC Health: Minister of Health on progress made in National Health Insurance Pilot, its achievements and challenges

Summary:
The Minister of Health, Dr Aaron Motsoaledi briefed the Committee on the progress made by the Department on the National Health Insurance (NHI) pilot districts. According to the World Health Organization (WHO,) a health care system needed to have six building blocks, and health systems financing was one of the building blocks for South Africa’s National Health Insurance (NHI) initiative. The NHI system would be implemented in phases, and would be complemented by a reduction in the relative cost of private medical care. The system would also be supported by better human capacity and systems within the public health care sector. The main thrust of the NHI included strengthening the capacity of the public health infrastructure to provide effective, safe and quality services. Infrastructure included staffing, buildings, technologies and utilities such as water, power and financing. Health infrastructure entailed public investment, and government needed to explore innovative ways of harnessing the resources of the private sector, non-governmental organizations and communities.
The Department had commenced with the NHI piloting of 11 districts. The pilot included the re-engineering of the primary healthcare system, which had three streams. These were the school health programme, the municipal ward-base primary healthcare agents, and the district specialist health teams. The Department was also looking to contract general practitioners (GPs) to work in
Members asked whether there would be a uniform design for the clinics, to reduce costs. Would there be adequate training for staff at the pilot clinics? What was being done to resolve security problems at clinics, particularly those in rural areas? Could the loss of staff from public health facilities to the private sector be reduced? Was the Department taking sufficient action to deal with HIV/AIDS, tuberculosis and the “sugar-daddy” issue? The Minister was also asked whether any action was being taken on the proposal by a Member of Parliament that dagga be legalised for use in the treatment of cancer.

Minutes:
The Chairperson welcomed the Minister of Health to the meeting, together with Members of the Committee.

**Briefing by Minister of Health**

Dr Aaron Motsoaledi, Minister of Health, thanked the Committee for the invitation. He said according to the World Health Organization (WHO) a health care system needed to have six building blocks, and health systems financing was one of the building blocks for South Africa’s National Health Insurance (NHI) initiative. The NHI system would be implemented in phases, and would be complemented by a reduction in the relative cost of private medical care. The system would also be supported by better human capacity and systems within the public health care sector. The main thrust of the NHI included strengthening the capacity of the public health infrastructure to provide effective, safe and quality services. Infrastructure included staffing, buildings, technologies and utilities such as water, power and financing. Health infrastructure entailed public investment, and government needed to explore innovative ways of harnessing the resources of the private sector, non-governmental organizations and communities.

The Department had commenced with the NHI piloting of 11 districts. The pilot included the re-engineering of the primary healthcare system, which had three streams. These were the school health programme, the municipal ward-base primary healthcare agents, and the district specialist health teams. The Department was also looking to contract general practitioners (GPs) to work in public clinics. An Infrastructure Optimization Tool Kit was being applied for the selection of clinics to be built in four provinces -- the Eastern Cape, Free State, Limpopo and the Mpumalanga NHI districts. The Department had compiled a District Hospital Assessment Report for each facility under the NHI project. The assessment included the building structure (walls, doors, roofs etc), building wet services (plumbing, drainage, and sanitation), electrical, civil infrastructure (roads, fencing, cleaning and site keeping) and mechanical equipment and installations. The following district hospitals had since received infrastructure upgrades: Pretoria West District Hospital, Jubilee District Hospital, Odi District Hospital, and Tshwane District Hospital.
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The WHO service availability and readiness assessment methodology provided a standard health
facility to assess, map and monitor service availability and readiness. It was designed to support a
health facility census with a focus on the core functional capacities and the availability of services.
The key topic areas and core functional capacities of a facility census of service availability and
readiness included:

- Identification, location and managing authority of health facilities;
- Availability of basic medical equipment, such as weighing scales, thermometers and
  stethoscopes;
- Availability of a health workforce
- Availability of general medicines;
- Availability of diagnostic facilities;
- Availability of general injection, sterilization, disposal and hygiene practices; and
- Availability of specialized services such as family planning, maternal and newborn care, child
  health, HIV/AIDS, tuberculosis, malaria and chronic diseases.

Dr Motsoaledi gave a summary of the Department’s work with the ideal type of clinics and said
that in total, 102 clinics had been built.

**Discussion**

The Chairperson thanked the Minister for the presentation. He agreed that one of the main reasons
why access to universal health had failed was the lack of infrastructure. Equity in infrastructure
was crucial to achieving this universal goal.

Ms M Dube (ANC) asked whether there would be some uniformity with the clinics being built and
upgraded.

Ms M Segale-Diswai (ANC) asked whether the Department would be providing adequate training
for the staff who would be employed in the pilot clinics. In order to involve local communities in
the NHI initiative, she suggested that a community indaba be held in all communities. Local
community members could also be well educated about the Department’s plans during these
engagements. Many appointments of security companies for local community clinics were
centralized at provincial offices, and as a result, the nursing staff for these clinics had no one to
complain to. The centralization of security companies caused problems at the local community
level.

The Chairperson asked whether the medical staff who were leaving public health facilities for the
private sector, were leaving for financial reasons. If not, what where some of the other reasons for
Ms S Kopane (DA) asked about the progress the Department had made towards attracting private general practitioners to work in public clinics. How many doctors from private hospitals where willing to join the NHI initiative? How far was the Department in finalizing the White Paper? What were the total costs of changing and/or upgrading the current infrastructure? How was the Department planning to upgrade the current filing system at local clinics in order to accommodate the ideal prototype clinic?

The Chairperson asked what the lifespan of these prototype clinics was. How would provinces be budgeting for the maintenance of these new structures?

Ms D Robinson (DA) also asked about progress on the White Paper. According to a presentation by the Department, HIV/AIDS patients were increasing at an alarming rate throughout the country. How was the Department looking to improve on its capacity to accommodate this growth? How were the campaigns for HIV/AIDS prevention being adequately promoted? How was the Department dealing with the alarming number of youth pregnancies? How were safe sex practices being promoted? Were there specially trained staff at these new clinics, to deal with these challenges? What plans did the Department have for educating men on the “sugar-daddy” issue?

The Chairperson reminded Members about a recent debate in the media around a suggestion that young girls be given some incentives for not having sex until they were 25 years old, or until marriage. How would the Department respond to this suggestion?

Ms R Motsepe (ANC) thanked the Minister for the presentation. She asked how the Department would be monitoring the construction of the projects. How long would the NHI project take? She informed Members that there was a new phenomenon among the elderly -- to use condoms as a remedy for arthritis. Had the Department any plans to conduct further research on this? What plans did the Department have to improve and educate current community health workers?

The Chairperson said the Committee would be very interested to know about the progress made by the Department concerning matters of legislation. How far was the transformation of the Medicines Control Council (MCC)? What other pieces of legislation were in the Department’s pipeline?

Ms B Ngcobo (ANC) asked whether newly-qualified nurses were still being sent to work in rural schools. Why were doctors and nurses no longer wearing their white uniforms -- was this no longer a requirement?

The Chairperson said the Medical Research Council (MRC) was receiving more money from donors than from the Department. He raised a concern that the MRC would then be reporting more to
these donors than to the Department, because more funding for research came from the donors.

Mr D Kganare (DA) thanked the Minister for the presentation. He said some dentists in Rooderport were interested in becoming part of the NHI, but they did not have access to the relevant information. How was the Department bringing private hospitals on board to the NHI? How would the NHI be linked to the licensing of private hospitals? What projections did the Department have concerning the full rollout of the NHI process? Was it possible that the Department would include the issue of private security at its MinMec?

The Chairperson said according to the presentation, the NHI pilot was focusing on eight districts. What plans were in place to include the rest of the remaining districts?

Ms Ngcobo said TB was another serious problem on the African continent in general. What plans did the Department have to tackle this problem? Had the Department made financial provision for the maintenance of the clinics with their expensive equipment? What would be the cost of building these clinics, and what was their lifespan? In some of the provinces there were clinics which had been built by private companies and/or private organizations, but some were either very small or dilapidated. Were these private clinics included as part of the NHI upgrades? Accommodation for clinic personnel, especially in rural communities was a serious challenge -- how was the Department planning to address this? How would new personnel be attracted to these rural communities?

The Chairperson explained that in the rural areas, there were different kinds of private clinics. Some used to be private hospitals -- missionary hospitals built for local communities, and which were not for profit. An example of this was one which was built at Lusikisiki in the Eastern Cape -- the clinic was built by Anglo American for the families of the mine workers.

Dr Motsoaledi thanked Members for their engagement with the presentation. He said that the Department would be using a uniform structure for the NHI clinic project. The Department had found that each contractor for building a clinic had a unique design, and this was very costly for the Department. As a result, it was moving away from this practice. There would be one design which belonged to the state. He made an example of the design which was used by the Western Cape Health Department to build the Khayelitsha hospital. That design was owned by the state. A decision had therefore been taken at MinMec that hospitals at district level would have one design. Tenders would be issued only where technical issues, such as topography, were involved. He agreed that some designs would not work well with topographical matters, such as soils in some areas, and in these cases a new design would be used.

On the question of professionals leaving public health facilities to join private ones, he said the matter was not unique to South Africa. It was a global phenomenon. Skilled people all around the world moved to greener pastures and there was not very much governments could do about this.
Canada, for example, was one of the main countries which lost doctors to the United States. A resolution had been taken by the WHO, however, that no first world country must actively recruit health workers from developing countries. However, the Sub-Saharan African region had been declared a crisis area by the WHO because not all countries were compliant.

The Chairperson asked what other plans the Department had in place for improving infrastructure.

Dr Motsoaledi replied that part of the resolution was that the Department would follow the service conditions put in place by the WHO, such as providing good accommodation and transport for staff etc. He argued, however, that no African country could ever compete with the Middle East in terms of taking care of health personnel, and unfortunately this was one of the main countries to which South African health professional moved.

On the question of private security companies being centralized at head offices at provincial level, he agreed that centralisation was a challenge. This meant that the tenders were being issued from elsewhere, and local clinics had no say in this. He agreed that local clinics scored very low on security capacity. Security companies received very big tenders from the Department but the money these security companies paid security guards was appalling, and this did not motivate security guards to work optimally. In one hospital, the service provider was receiving R500 000 from the tender, while security guards were being paid R1 200 per month. The Department was, however, exploring the suggestion of removing security companies and paying security guards directly. A resolution had therefore been taken at MinMec that each hospital should appoint its own security provider.

The Department was still struggling with the question of recruiting general practitioners to local community clinics. Many of these private practitioners argued that the conditions of the local clinics were not good, so they would wait for the improved, “ideal type” clinics. Salary improvements were also another concern for private practitioners. The ideal type clinics pilot had been costed. The accurate figures would be forwarded to the Committee. On the question of the filing system, he agreed with the Member’s suggestion that the current one be upgraded to include the NHI system. In 2012 the Department had looked for unemployed graduates who had qualifications in finance, human resources and information technology. 400 of them had been given training on public service, and then given internships by the European Union on behalf of the Department. These interns had computerized the whole filing system of the Department.

Dr Massoud Shaker, Head: Infrastructure, National Department of Health, replied to the question on infrastructure and explained that maintenance was very expensive due to the fact that on average it took the Department five years to complete a building. Therefore by the time the structure was completed, the building was already deteriorating. The longer it took to complete the building, the higher the maintenance costs.

Dr Motsoaledi said provinces should be encouraged to spend money on infrastructure
maintenance, rather than on building new hospitals or clinics. Therefore, with the conditional grants allocated to provinces, provinces would be mandated to spend at least 30% of this allocation on maintenance, rather than on building new structures.

With regard to the White Paper, he asked the Committee to wait for a report from the Minister of Finance. He replied to the school health question, and agreed that the matter was of serious concern.

Regarding the use of condoms as a remedy for arthritis, he said it would be very costly for the Department to conduct research on all new innovations. The Department had established the National Health Research Committee (NHRC,) which was chaired by Professor Bongan Mayosi, the Head of Medical Research at the University of Cape Town. This committee was responsible for assessing the relevance of new medical research.

On the question on white uniforms, he said a resolution was taken in 2010 that all nurses needed to wear white uniforms.

The Department had started preparing for the NHI in 2002, and it was anticipated that the whole process would take 14 years. **Therefore 2016 was the completion date.** He said the National Development Plan was one of the main guiding documents for attracting the private health sector to work with the NHI system. **One of the main priorities of the Department, however, was to do away with the exorbitant fees at private health institutions.** The pilot for the ideal type clinic would be rolled out in all provinces, except for the Western Cape.

On who was responsible for maintenance, he said the Department was busy training people who would be responsible for this area. The lifespan of the new ideal clinics was 50 years. Clinics, such as those in Lusikisiki, which were built by private organizations, were still managed by government and would therefore be included in the Department’s upgrades.

On the question of nurses who were allocated to work in schools, he said the Department was hiring retired nurses to assist newly-qualified nurses. However, the number of nurses was not enough to cover all schools. Nursing teams were therefore rotating schools for the rollout of the school health programme.

TB around the Southern African Development Community (SADC) region was a big problem -- 80% of the TB in the world was found in 20 of the countries in the world, and all BRICS countries were part of this 20. 80% of all people who died from AIDS were killed by TB. The Department was therefore heavily committed to fighting against the disease.

The Chairperson thanked the Minister for the responses.

Ms Segale-Diswai asked what decision the Department had taken on the Member of Parliament’s proposal to legalize dagga for medicinal use.

Dr Motsoaledi said it was not the first time that a proposal had been brought before the Department for dagga to be legalized for medical purposes, but the most recent proposal was seen
as controversial, because it had come from a high profile individual. This also made it difficult for the Department to address the proposal. The proposal was very sensitive. Individuals were allowed to apply to the MCC to be granted individual rights to use a non-medical substance such as dagga for treatments of various illnesses, such as cancer.

The meeting was adjourned.

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