1. National Health Insurance (NHI) Pilot Districts: progress report by Minister of Health

2. Chairperson: Ms M Dunjwa (ANC)

3. Date of Meeting: 21 August 2015

4. Summary

Dr Aaron Motsoaledi, Minister of Health, and a delegation from the Department of Health provided an update about the National Health Insurance (NHI) pilot sites. The programme focuses on the development of infrastructure for primary healthcare systems and the recruitment of doctors and specialists for clinics. Minister Motsoaledi emphasised the importance of efficiency in human resources management in building up the public health sector. He explained the Department’s consultations with both the World Health Organisation (WHO) and Harvard University in pursuing the NHI programme.

The Department presented the design for an ideal clinic, and is working to complete construction on such clinics in the ten pilot districts; 106 structures have already been completed. The districts were chosen as representative of the country’s widely diverse demographics, so they therefore vary in size, population, and level of poverty. The Department is working on construction and budgetary matters in conjunction with the Department of Public Works and the National Treasury. Though it has been challenging for the Department to attract doctors and specialists to work in the clinics, the Department has many methods of recruitment as well as training programmes in place for former or current clinic volunteers. Efforts are also underway to address the critical issues of wait times and school health care services.

The Committee had many questions due to the complexity of creating a national health care system, but generally lauded the Department’s efforts and its focus on primary healthcare. Members asked general questions about the influence of business on public health, oversight of and budgeting for programme spending, the Department’s ability to build public confidence in the programme, school healthcare services, and doctor recruitment as well as specific questions about x-ray machines in clinics, examples of clinic construction projects being behind schedule, recruiting doctors from SADC countries, and clinic security.

Minister Motsoaledi noted that many funding issues would be clarified in the soon-to-be-released White Paper, pending work by Treasury on the White Paper. He gave examples where Australia had cracked down on the tobacco industry and said that the Department is working with and drawing funding from the private sector for public health initiatives. The Department will build confidence in the NHI programme over time as the public becomes familiar with the programme. The foreign recruitment of doctors is highly contentious, and Minister Motsoaledi noted that, worldwide, there is a general shortage of doctors. The Department is working with Treasury on infrastructure matters and grant money allocation. He told the Committee that the clinics had x-ray machines and proper security measures, and again emphasised the importance of HR structures.
5. Minutes

Opening Remarks
The Chairperson commented that today’s meeting is very important because it involves the health of the people. She referred to the country’s past history that must be corrected by the health sector. She commended Minister Motsoaledi for creating one of the most effective programmes in South African history.

Briefing by Minister of Health
Dr Aaron Motsoaledi, Minister of Health explained that at the beginning of the NHI project, the Department estimated that the process would take 14 years. Pilot sites were chosen according to a mix of both size and poverty levels of such districts. He noted that because KZN is so much bigger than other provinces, it got a second location. The programme had four targets:
- Infrastructure Development
- Contracting GPs to work in Public Clinics
- Re-engineering the Primary Healthcare System
- Quality of Health Services.

Minister Motsoaledi said that all these tenets emphasise the primary healthcare system: the people must be able to go to clinics and receive quality care. Minister Motsoaledi noted that, although the Department probably will not meet the NDP goal of 11 million healthcare workers, it has raised the number of workers significantly.

At a WHO meeting in Tunisia in 2012, Dr Luis Sanbo of the WHO helped African leaders tackle the concept of Universal Health Coverage. The first step is improving infrastructure, from staffing to waste management. Therefore, the DOH has assessed the status of infrastructure of each district. Minister Motsoaledi presented charts cataloguing the status of each building in each district. Vhembe has mostly small structures, but generally good status. Tambo, on the other hand, was mostly in the red and thus needed re-building. The Department has, in the past, struggled with DPW to get these improvements made.

Minister Motsoaledi presented the architectural diagram of an ideal new NHI clinic, designed by specialists from various fields. This design will also aid current clinics in remodeling. He explained that clinics must have separate consulting rooms for doctors lest the doctors distract the nurses. As of yet, 106 of these structures have been completed.

After this construction, the Department began the slow process of contracting GPs. Minister Motsoaledi noted that it is difficult to motivate doctors to work in a clinic or in a rural area, but that direct contracting has helped recruitment. The charts showed the exact breakdown of doctors hired in each district. Three options for contracting were tested:
- Direct Contracting through the NDOH
- Service Provider
- Western Cape Option

Minister Motsoaledi noted that Cuba has some of the best healthcare in the world, and that Cuba recently ended mother-to-child HIV transmission. He then explained the various treatment options for diabetes, and stated that the best yet least glamourised treatment option is good diet and exercise. This example shows that it is difficult to glamourise and promote primary health care so as to provide primary care at the quality level of a country such as Cuba. However, public perception must be improved in order to re-engineer primary health care.

The Department chose seven professions that must be present in each district: a midwife, an anesthesiologist, a family physician, an obstetrician, a pediatric nurse, a pediatrician, and a PHC
nurse. A report on these specialists is being constructed at the moment.

Minister Motsoaledi reminded the Committee of the HIV epidemic of the late nineties and how the response was unplanned and mostly done by volunteers. The legacy of this has caused many people today to want jobs in primary healthcare, but they come from a variety of levels of training. The Department is creating standards for worker qualifications, from HIV and TB to mental health and immunisation practices. In KZN, all of the former workers were trained together under one roof for the pilot programme.

To improve school health services, 27 mobile PHC trucks, 17 oral health mobiles, and 3 eye care mobiles have been commissioned. In order to ensure that kids are successful in school, health care must address eye and mouth health, immunisation, illegal substance issues, HIV prevention, and reproductive health. HIV prevention and reproductive health education is still controversial, but the other three are working well. Out of 280 000 children screened at this point, one third had some kind of speech, hearing, or sight issue.

The NHI project aims to improve healthcare systems and administrative practices. Nurses currently spend too much time filling out registers. The NHI plan reduce the number of registers from 56 to 6, which will reduce waiting time and increase patient interaction time. The project has found that an Automated PHC Patient Information System to make the system paperless will greatly improve efficiency and more efficiently use the space of small clinics.

Today, over three million South Africans are on ARVs and go to clinics; the infrastructure is not keeping up with the increasing number of patients and thus waiting times are a critical problem. In addition to improving registers, the project aims to improve chronic medication dispensing by allowing a service provider to handle chronic medication. Admittedly, this is logistically difficult with patients who have more than one condition. Another area for reform is the process of hospital reimbursement.

Minister Motsoaledi informed the Committee that the Department has completed its part of the White Paper, but the Treasury and the Cabinet have work to do before it is published.

Discussion
Mr A Shaik Emam (NFP) thanked the Department and observed that it is the Department’s inability to appoint provincial officials that causes bad wait times. He asked whether enough is being done for disease prevention and health promotion? He noted that the advertising on the media overwhelmingly advertises for unhealthy foods and practices. He observed that staff attitude is a problem, but recognised that the Department is trying to attract motivated health care workers. He said that the private sector might need to play a greater role in healthcare. He observed that clinics would take time to address historical gaps in healthcare. He noted that there are GPs available in SADC states, and asked whether they will ever be used.

Dr W James (DA) said that he supports the emphasis of primary health care and the building of clinics. He noted that infrastructure delivery schedules are a constraint. He shared complaints from five clinics being constructed in the Free State that contractors are being overpaid, though he noted that these are not necessarily NHI pilot sites. What is the Department doing to oversee the flow of money? He lauded the example of Cuba, but noted that training for the future of mid-level workers will be necessary; what is being done for this? He noted that the NHI grant has been cut, and that a national health care system will be enormously expensive. Why has the money currently allocated not been spent?

Dr P Maesela (ANC) observed that, even if children are checked at school, they then have nowhere to go for treatment; how is this being solved? He noted that nutritional education is lacking, and should
be run by the Department rather than contractors. He asked why the Western Cape is opting out of the NHI and noted that many specialists do not want to go to rural areas. He suggested that all schoolchildren should be given cell phones.

Mr H Volmink (DA) asserted that universal health coverage is a moral imperative. He noted that NHI is a vehicle to achieve this, and that the government must be willing to change this vehicle. Should the 14-year timeline be revised? How will the lack of confidence in healthcare and confusion about NHI be reversed? He noted that preventative healthcare to target major health risks like smoking must improve; how has preventative care been integrated into the NHI system?

Mr I Mosala (ANC) welcomed the 12 month progress report and pointed to page 4 of the document concerning conditional grants and asked how close is the government to reconciling differences between Treasury and Health on the grant? Will we have a new approach created next year? He noted that only 55% of expenditures noted in the presentation were for medical equipment. Why is there a disjuncture between national practices, provincial practices, and district practice in relation to infrastructure spending? What will the progress be for the 2015/16 financial year on infrastructure development? Where is the information from the Western Cape? What was the impact of the district specialisation; can we have a report on this as well as on other specific NHI programmes?

Dr H Chewane (EFF) lauded the emphasis on primary healthcare as a gold standard. Will clinics have x-ray facilities? He said that many patients who need clinic services also need x-ray services. He said that the Department should relook at outreach workers to reach rural patients who otherwise would not seek care until the late stages of a condition. How does the Minister feel about tender? He noted that incidents of assault on doctors have occurred; are you considering security for these clinics?

Mr S Jafta (AIC) asked why the pace of recruitment of GPs is slow, especially after the inclusion of service providers? What is the Department doing to encourage learners to become GPs? He said that the Tambo district of the Eastern Cape needs urgent attention.

Ms C Ndaba (ANC) supported the hiring of service providers to deliver chronic medication as a solution to wait times. She was impressed by the Department’s performance in Vhembe because she saw a clinic there with all the specialists necessary. However, she noted that on oversight visits, providers had complained about establishment records preventing staff from appointing extra help, what is the Department doing to address this?

Minister Motsoaledi reminded the Committee that the NHI is a new concept to the country, and that each country has different health coverage with the goal of equal access to care. He assured Mr Volmink that the programme will gain momentum and recognition.

Minister Motsoaledi recognised the complexity of balancing business interests with health interests. For example, the Minister of Health in Australia took great strides and faces legal challenges from the WTO on her efforts to curb smoking. He gave an example of shops selling sweets in the checkout line and noted that the Department has taken efforts against salt, but not sugar. These issues, if too many people have diabetes for example, will be beyond Minister of Health ability to fix. A commission must be established that will include the Deputy President and representatives from private industry to address these dire health issues. Minister Motsoaledi in 2010 encouraged private healthcare to improve HIV care and investment in human capital; they agreed and this shows that public and private can work together. Funding raised by the private sector has sponsored PhD programmes in infectious disease research and trained CEOs for hospitals.

As for getting doctors from SADC, Minister Motsoaledi said that most countries worldwide have shortages of doctors; he quoted that there is a shortage of 4 million doctors worldwide. The WTO arrived at a resolution that countries must not recruit doctors from developing countries; this conflicts
with other bodies who assert that labour must be free to move anywhere. Though South Africa is a stronger economy than other SADC countries, it is hotly debated whether South Africa should recruit specialists. The EU as well as private hospitals already attract these specialists, but developing countries do not want to lose their doctors.

Minister Motsoaledi said that he was very aware of the infrastructure money issues raised by Mr James. He complained that Treasury has the authority on this issue, even though Health has the responsibility. Health has fought with Public Works to charge or terminate contractors and ensure that they finish on time, but Health lacks authority. As for mid-level workers, training and planning has only begun recently.

When the White Paper is released, it will be clear that NHI progress has been split into three phases and it will be reviewed whether the timeline will be kept. The first phase, or preparatory phase, will last five years and is almost complete. The second phase is to erect structures: payment systems, districts, etc. The final phase, lasting four years, will involve the establishment of the NHI itself. Minister Motsoaledi said about Qatar that they have been working on their NHI since 1992. Universal Healthcare will represent a major transition in human history.

Minister Motsoaledi explained that the Department is working with Treasury to allocate Grant money to National and Provincial levels fairly. Provinces require that there be a register in order to allow training at universities. Some of these issues must be changed in the White Paper. The first two years were difficult, but now buildings will be constructed and things will get easier. To implement NHI, a total re-organisation of the system will be necessary.

Minister Motsoaledi explained the introduction of an essential equipment list; this list includes x-ray machines. Primary Health Care has been improved significantly and successfully in KZN in order to address the prevalence of AIDS, and UN representatives have lauded the progress there. Each district has an MEC to advocate for its needs.

Minister Motsoaledi informed the Committee about Harvard University’s lecture series for Ministers of Leadership in Health. The lecture found human resources, procurement, and supply chains are all generally subpar in developing countries. If these areas improve, healthcare in the country will improve.

Minister Motsoaledi asserted that Health MECs will always be chosen by the Premier of that particular province. He said that this is a constitutional issue. HR, as shown by Harvard, is the first and most important building block.

Minister Motsoaledi assured the Committee that violence in hospitals is not a new issue, and the NHI will freshly strengthen security. The MEC for Health and MEC for Safety and Security must work together and pay their security staff better so there will not be such a high turnover of security personnel. The healthcare provider must know their security personnel.

Minister Motsoaledi explained that there are actually too many applicants for medical school admissions; we do not have enough medical schools. He agreed that Tambo needs extra attention, and he said that he has personally spent time there to work out HR structures.

Minister Motsoaledi observed that studies on the number of doctors per population are not conducted properly or transparently. In fact, frequently there are too many doctors rather than too few. These studies now account for prevalence of sickness and poverty levels, among other demographics using a specific mathematical formula. This will take time and work with Treasury to iron out budget issues and provide the necessary specialists.
The Chairperson emphasised that these matters deserve time and consideration. Minister Motsoaledi will visit the Committee again on 2 September to continue this event.

The meeting was adjourned.