10 *SDG10, reduced inequalities: the effect of health policy on inequalities: evidence from South Africa*

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10.1 Introduction

South Africa remains racially and economically segregated, despite the end of apartheid in the early 1990s. The country is plagued by persistent social inequality, poverty, unemployment, a high disease burden, and inequitable health care service provision. The South African health system is currently engaged in the complex project of establishing universal health coverage, which ensures the system's ability to provide comprehensive care that is accessible, affordable and acceptable to patients and families while acknowledging the system's significant pressures. Nonetheless, inequalities in post-apartheid South Africa have been extensively analysed, yet not much has happened as to the effect of health policy on inequalities in the country. This chapter provides an overview of the effects of health policy on inequalities in South Africa, emphasizing how SDG3 (health for all) and SDG10 (reduce inequalities) can fight the long-term societal inequalities. It explains the inequalities in South Africa, the country's available health policies, and how this has affected the long-existing trend in the country. South Africa is one of the most unequal countries in the world. The country's Gini coefficient is high and the highest among countries with comparable characteristics. The 10% richest of the population spend 7.9 times more than the 40% at the base. The inequality started during the apartheid period when racial separation was legislated and was a strategic area of policy concentration for the first democratic government. Today, years after the end of apartheid, though there is a decline, the country still battles to fix the differences despite sustained positive economic growth. The issue persists with racial footprint. The divide is visible in social, economic and health areas. This chapter aims to demonstrate the capacity for social innovation in health concerning South Africa and to highlight

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some current innovations that respond to issues of health equity, such as accessibility, affordability and acceptability.

10.2 Background

Transformative change is required to reduce inequality. Greater efforts are required to eradicate extreme poverty and hunger, as well as increased investment in health, education, social protection and decent jobs, particularly for young people, migrants and refugees, and other vulnerable communities. Thus, the United Nations General Assembly in 2015 published the 17 Sustainable Development Goals intended to be achieved by the year 2030 by all countries. The goals are aimed at peace and prosperity for people and the planet, now and into the future. Importance is attached to how a reduction in deprivation goes together with plans to improve health, education, equality, the economy and the environment. The SDGs focus on development as well as on restoring the dignity of people. Before the United Nations' SDGs, South Africa adopted the National Development Plan (NDP): Vision 2030 in 2012. The NDP closely lines up with the SDGs. It focuses on minimizing inequality, growing an all-encompassing economy, and eradicating poverty by 2030. The goals are incorporated into government planning systems and processes at the national, provincial and local levels. SDG10 aims to reduce inequality within and between countries. It advocates for the reduction of income inequalities, as well as inequalities based on age, gender, disability, race, ethnicity, origin, religion or economic status. SDG10 to reduce inequality is also one of the priorities of the NDP. This is especially relevant to South Africa. Growing inequality impedes long-term development, slows economic growth, and undermines social cohesion within societies. There is no international agreement that reducing inequality is critical to ending poverty by 2030.

The non-White population has consistently been in the lowest income and wealth strata. Households in this group rely more on social grants, whereas those at the top rely on labour-market income, which is heavily racialized and gender-biased. The South African labour market contributes significantly to overall income inequality. Aside from having dire employment outcomes, Black Africans earn the lowest wages. Nearly half of the Black population lives below the poverty line, compared to less than 1% of the White population. Recently, it was reported that between

2009 and 2015 there was a consistent increase in the average number of assets owned by the Black population. However, asset inequality persists even within different quintiles of the Black population groups. Most households in South Africa do not have access to clean water, while at least 14% live in congested informal settlements. The apartheid system forced Black South Africans into informal housing settlements which were cut off from infrastructure and overcrowded. Since the emergence of democratic rule, the government has funded millions of new homes for Black South Africans but these houses were developed within the settlements, sustaining the geographical segregation created during apartheid (Fogel, 2019). These settlements have little access to public services and utilities. Nonetheless, a South African child's educational experience is still a function of place of birth, socioeconomic status and skin colour. The COVID-19 pandemic further exposed this as students from poor communities were cut off from education during the lockdown as a result of inadequate internet connection (Mohamed, 2021). The educational system is faced with clear inequalities and lingering underperformance. Schools are plagued with collapsing infrastructure, congested classrooms and poor educational outcomes. Students learn in schools with inadequate infrastructure and a lack of essential facilities. Some 75% of South Africa's schooling system consists of public schools situated in peri-urban and rural areas. These schools are attended mostly by poor Black children and are faced with overcrowding, poor resources and dysfunctionalities (Vally, 2020). Based on a government report in 2018, 19% of public schools use illegal pit latrines, 37 schools had no sanitation facilities; 86% had no laboratory; 77% had no library; 72% had no access to the internet and 42% had no sports facilities. As a result, education outcomes differ. Students in the topmost 200 schools get more distinctions in maths than students in all the preceding 6600 schools.

10.3 Causal pathways between health actions (policy) and SDG10 (reduce inequalities) co-benefits

Poverty, social and economic inequalities, and disparities in access to basic social services between population groups and provinces are common and symbolic in South Africa, and this helps to worsen inequalities in health (Ataguba, 2010; Coovadia et al., 2009). The South African government has employed a variety of strategies to combat the persistent levels of inequality that have troubled the nation. Higher

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social expenditure, targeted government transfers, and affirmative action to spread asset ownership and encourage entrepreneurship among the once-underprivileged have been the main strategies utilized to alleviate inequality (IMF, 2020). Inequalities in socioeconomic status in South Africa help to aggravate inequalities in health. This is because low socioeconomic status leads to deprivation (Ojoniyi et al., 2019). Studies on the burden of some disease conditions in the country have shown persistently that the poor suffer more from numerous diseases and violence than the rich. There is greater reporting of disease and disability among those in low socioeconomic classes compared to those in high socioeconomic classes (Ataguba, Akazili & McIntyre, 2011). There are specific benefits that can be gained from actions in the health system in reducing inequalities (SDG10). In this case, the benefits are twofold. Health policy in health can help in reducing inequalities in health outcomes, which in turn is an indication of the success of SDG3.

There is a link between SDG3 and SDG10, especially concerning universal health coverage. The health system influences the social determinants of health, enhancing health outcomes and tackling social inequalities (Gilson et al., 2007). To achieve this goal, the country aims to implement the National Health Insurance (NHI) and establish a unified health system. The NHI white paper prepared by the government of South Africa admits that good health is an essential state of humans' socioeconomic life and is a crucial precondition for poverty reduction, continued economic growth, and development. In a study conducted in the country, high socioeconomic status and perceived risk of HIV were associated with a decreased risk of infection (Mabaso et al., 2019). However, the link between universal health coverage and health inequality reduction is not so clear-cut, as it has been shown that higher socioeconomic groups use more services and have greater access to health care.

Also, the white paper recognizes that social factors contribute immensely towards improved health outcomes and long healthy life in the country. Poverty has been a principal factor promoting inequality in HIV prevalence among race groups created by historical and current unequal social and economic status in South Africa (Sia et al., 2014; Zembe et al., 2013). This requires a multisectoral approach to addressing social determinants of health. The NHI programme targets health promotion, prevention of disease, and empowering of communities. It

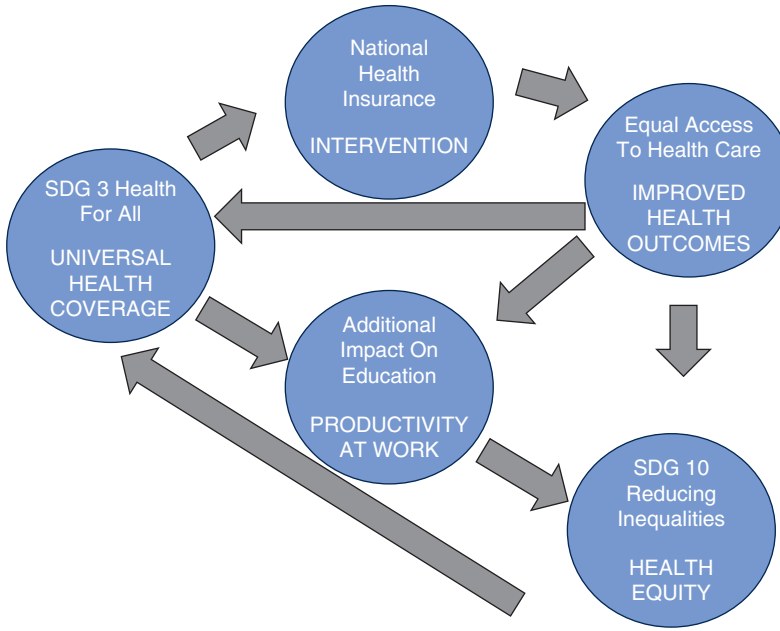

Fig. 10.1 Mapping proposed causal pathways between health policy and equality

intends to remove financial barriers to access to health care by transforming the financing of health services and extending population coverage.

Fig. 10.1 shows some of the pathways between SDG3 (health for all) and SDG10 (reducing inequalities). It starts with the NHI and continues with equal access to health care, which in turn contributes to SDG3, impacts education and productivity, and in turn impacts SDG10. Furthermore, there is a direct link from SDG10 to SDG3 in the medium to long term. Specifically, it depicts the pathways through which the NHI will help in reducing inequalities, particularly in health outcomes. The NHI is a health intervention aimed at reducing unequal access to quality health care, which will also result in better health outcomes, thereby achieving the goal of reducing inequality in health. Similarly, the health intervention will give room for equal access to quality health services irrespective of level of income, which will result in better health outcomes that will promote productivity at school and work with a resultant effect on educational and work outcomes. Improved educational and work outcomes will further reduce social inequalities.

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Aside from the NHI scheme, the country has shown commitment to reducing inequality in the country. The first Voluntary National Review towards the realization of the SDGs shows the impact and programmes of the nation and multi-stakeholders' contributions to the achievement of the agenda. There has been an improvement in the living conditions of millions of South Africans: significant progress in education for children from poor households, with over 9 million children attending no-fee schools; more individuals now benefit from the social protection system (up to 17.5 million individuals in 2018); provision of clean water and electricity; over 4.5 million people benefit from the antiretroviral treatment programme which is the biggest in the world; increase in the representation of women in national parliament and legislature; and increasing actions to generate more employment (United Nations, 2019). However, high levels of inequalities, discrimination and violence against women remain.

10.4 Country case study

Since the end of apartheid 27 years ago, significant progress has been made in improving the lives of South Africans. The apartheid government's segregated population now has greater access to infrastructure and social amenities. However, the country is still battling apartheid-era racial segregation, inequalities and poverty. To reduce inequity and inequality, there is a need for equal access to public services. Poverty and employment status affect access to health care services and also have a great impact on nutrition and living conditions. South Africa has a well established economy and is classified as a middle-income country; since 2000, the average annual growth rate has been over 4.5%. Despite the economic growth, job creation and the wealth created are not evenly distributed. In South Africa, health care access for all is constitutionally protected, yet considerable inequities remain, largely due to distortions in resource allocation. Access barriers also include vast distances and high travel costs, especially in rural areas; high out-of-pocket payments for care; long queues; and disempowered patients (Harris et al., 2011). South Africa has four coexisting epidemics: poverty-related illnesses; maternal death and malnutrition; HIV/AIDS; and the growing burden of non-communicable diseases.

The origin of the dysfunctional health system and the collision of the epidemics of communicable and non-communicable diseases in South

Africa can be found in policies from various periods of the country's history, from colonial subjugation to apartheid dispossession to the post-apartheid period (Coovadia et al., 2009). The political, economic and land restriction policies during the apartheid era organized society by race, gender and age, which critically influenced the structure of family life and access to basic resources for health and health services. The unfair migration trajectory of rural male Black labourers to the towns was enforced by the economic situation at that time. Failure to provide proper housing for the migrant workers in urban areas led to the creation of overcrowded, unsanitary hostels and slums in the urban Black townships. Thus, the increased number of mine workers, and the repatriation of workers who were too ill to be productive, spread tuberculosis to the rural areas (Coovadia et al., 2009).

The SDGs at the global level and the NDP at the national and local levels give the country a platform from which to tackle its prevalent social problems. Both the SDGs and NDP target the year 2030. While the National department is responsible for policy formulation, the Department of Health, the caretaker of the South African health system, is a factor in the achievement of Priority 2 (education, skills and health) of the government's 2019–2024 Medium Term Strategic Framework, and the vision articulated in Chapter 10 of the NDP, such as reducing the burden of disease and strengthening the provision of health care to improve the lifespan of South Africans. Over the medium term, the Department of Health is expected to focus on carrying out the staged execution of NHI, investing in health infrastructure, preventing and treating communicable and non-communicable diseases, and financing tertiary hospital services. NHI is a system of health care funding in which all taxpayers or income earners make compulsory contributions, but the whole population is entitled to the benefits, including those who do not contribute. The introduction of the NHI scheme in South Africa is intended to push the health care system towards a socialized model – this is a state-supported service funded by taxation with little or no additional cost to the consumer. The purpose of the NHI is to cover the entire population with adequate health care at an affordable price. This system is not discriminatory. It is aimed at ensuring that everyone in South Africa has access to quality health services provided by both the public and private sectors irrespective of socioeconomic status. This system will reduce the disparity in health outcomes caused by inequality in socioeconomic status.

Table 10.1 *Governance actions and intersectoral structures of the National Health Insurance*

			Possible governance actions with these tools								
			Goals and targets	Evidence support	Policy guidance	Implementation and management	Coordination	Advocacy	Monitoring and evaluation	Financial support	Legal mandate
Tools	Plan	Plan	X						X		
	Indicators and targets	Indicators	X						X		
		Targets	X						X		
	Budgeting	Pooled budget								X	
		Shared objectives								X	
		Coordinated budgeting								X	
	Organization	Ministerial linkages				X					X
		Specific ministers			X	X					X
		Organization			X	X					X
		Legislative committees	X		X	X					X
		Interdepartmental committees/units				X					X
		Departmental mergers				X					X
		Civic engagement				X		X		X	X
	Accountability	Transparent data	X	X					X		
		Regular reporting	X	X					X		
		Independent agency/evaluators		X					X		
		Support for civil society									
		Legal rights									X

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The NHI aims to increase access to high-quality health care for all South Africans, safeguard people financially from medical bills, and establish a public fund for all health services. To achieve the patient-centred, decentralized NHI that the government desires, a high level of organization and health service coordination is required. The government is to ensure that the constitution is met by finding all the resources available. The Health Professions Council of South Africa (HPCSA), on the other hand, is to ensure quality assurance, enforce professional codes of conduct and ethics, enhance human resources for health, and advocate for the proper regulation of private hospitals (National Health Insurance Bill, 2019).

The South African government started to implement the NHI in growing phases to secure public trust and improve public health services and infrastructures (Mkhize, 2019). It has been difficult to get public support for the scheme. The engagement of prominent leaders is required to get both public and political support for the implementation (Mkhize, 2019). The whole idea of the NHI is to gather public revenue to generate funds to eradicate inequality in access to health care between the private and public sectors (Onoka, Hanson & Hanefeld, 2015). The public has shown much concern about how much tax they will pay (National Health Insurance Bill, 2019). Hence, the government needs to show greater transparency and accountability on the matter.

The NHI programme is planned to achieve universal access to health care in South Africa. It is a policy priority. The national budget review indicated the provision of additional funds on health accounts to cover NHI. However, there is a need to present the programme effectively to the public for the average citizen to have a feeling of control. It is portrayed as a financial system designed to source funds for the provision of health care services to all citizens and this has made promoting the plan tricky. This is because the majority of the population use public health services while very few have access to medical aid insurance.

The support for this programme will no doubt increase if the plan is communicated and executed efficiently. Public knowledge about NHI is deficient and based on negative sentiments made openly by those who oppose it (Welthagen, 2019). However, NHI is a reality for developed nations with the success of the programme recorded in Sweden and Germany. As a result, this programme can be said to be of high political importance and low political conflict, as illustrated in Table 10.2 below.

Table 10.2 *Political importance and conflict of NHI in South Africa*

		Conflict	
		Low	**High**
Political importance	High	X	
	Low		

NHI is about fairness and social protection, and it reflects the type of society that South Africa should strive to be: one that values justice, fairness and social solidarity. The NHI programme is based on the idea that all South Africans, regardless of socioeconomic status, should have access to necessary, high-quality health care services that are provided at no cost. This would protect the population and households from financial difficulties caused by the use of health care services. Vulnerable groups would be given priority. The South African health system has a history of inequity and fragmentation and has been characterized as a two-tiered system with public and private health care providers. South Africa spends around 8.6% of its GDP on health care, which is similar to that of other middle-income countries. However, 84% of the population is uninsured and is handled by an overburdened public health system, while 4.4% of GDP is spent on the 16% of the population who are covered by private medical schemes and who, for the most part, get their health care services in the private sector. Aside from financial resource discrepancy, the health system is marked by human resource maldistribution, with a large share of health care professionals working in the private sector relative to the population. This occurs in the context of a rising disease burden owing to communicable and non-communicable diseases, high maternal and child mortality, and trauma and injuries.

NHI aims to bring South Africa nearer to universal health coverage, in which the entire population, particularly vulnerable populations, is covered; everyone has access to needed quality health services; and households are protected from financial risks and out-of-pocket payments when obtaining health care services, resulting in a unified health system. The NHI programme aims to revolutionize the financing, purchasing and delivery of health care services, based on the requirements of Section 27 of the Bill of Rights, which calls for

the progressive realization of the right to health. The NHI is being implemented in three stages over a period of 14 years, which started in 2012, by the National Department of Health. The first phase was implemented between 2012/2013 and 2016/2017. It involved piloting several schemes in readiness for the implementation of the full NHI. Also, workstreams were created to improve the policy and feed in recommendations from the phased implementations. One district was selected in every province in the country apart from Kwazulu-Natal, where two districts were selected, to serve as NHI Pilot districts. The 10 pilot districts were proposed as the location for innovation and testing all through the execution of the first phase of NHI (Setswe, 2020). The operations at this phase were:

(1) ward-based primary health outreach teams (WBPHCOTs) targeted to promote preventive health care to households;
(2) the integrated school health programme (ISHP) aimed at providing health promotion services for school-age children at their schools;
(3) general practitioner (GP) contracting to increase the number of GPs at primary health care (PHC) facilities for improved quality and acceptability of care;
(4) the ideal clinic realization and maintenance model (ICRM) which involved creating minimum standards to increase the quality of services;
(5) district clinical specialist teams (DCST) to aid clinical governance and carry out clinical work, research and training;
(6) centralized chronic medicine dispensing and distribution (CCMDD) to enhance the delivery of medicines, including chronic medication, to patients at pick-up points nearest to the communities;
(7) the health patient registration systems (HPRS) started with capturing patient data and the generation of electronic files but with the ultimate goal of a fully electronic patient record system;
(8) a stock visibility system (SVS) to improve stock lapse using an electronic stock monitoring system to ensure appropriate and timely ordering;
(9) infrastructure projects implemented to improve health infrastructure to ensure increased access and quality of care; and
(10) a workload indicator for staffing needs (WISN), a WHO planning tool intended to help facility managers make more efficient staffing decisions.

Phase 2 (2018–2022) was intended to identify interventions that worked in phase 1 and expand them across provinces and facilities. It focuses on developing the legislation currently in progress. It involves systems and process development for effective management of the NHI Fund. Improvements for this phase (Table 10.3) are found in the financing, health service provision, governance and regulation sectors (NdoH, 2019).

Phase 3 (2023–2026) will expand the health systems and reinforce their activities to full scale. It will involve the introduction of the compulsory prepayment for the NHI, engaging accredited private hospital and specialist services, finalization and implementation of the Medical Schemes Act and NHI Act.

10.4.1 Evaluation of NHI Phase 1

The evaluation for phase 1 was done from November 2017 to December 2018 by a consortium in the country led by Genesis Analytics. The phase was focused on consolidating the health systems. The evaluation report according to the Consortium revealed that there were both challenges and successes (Writer, 2021). All the projects were successful but there were some recommendations, although it was difficult to measure the overall impact of the intervention on access to and quality of services owing to some factors.

Findings from the evaluation revealed the significance of leadership and good governance. This is evident in some of the interventions where committed leaders who embraced the vision of NHI ensured vigorous implementation. The lessons learned from phase 1 will be incorporated into the phase 2 intervention. Notwithstanding, the implementation has been successful in reducing inequality.

10.5 Discussion, conclusion and outlook

Socioeconomic status is related to health outcomes. One area that suffers from inadequacy or deprivation of another aspect of life is health. Studies have shown that inequalities in socioeconomic status are the root cause of health inequalities (Harper & Lynch, 2007; NdoH, 2019). The development of NHI in South Africa is aimed to level out the inequities in public health care by promoting access to health care amongst all South Africans without affordability as a concern.

Table 10.3 *Areas of improvement in the Phase 2 implementation*

	Areas of operation			
Sector	**Financing**	**Provision**	**Governance**	**Regulatory**
Public sector	(1) Restructuring equitable share (2) Establish a cost-based budget and introduce a case-mix-based budget for hospitals (3) Establish clinic budget and introduce capitation contracting for primary health care (PHC)	(1) School health, maternal and women's health (2) Mental illness, elderly, disability and rehabilitation (3) Expansion of service benefits, and implementation of PHC services through the first 1 000 clinics	(1) Establish central hospitals as semi-autonomous structures (2) Strengthen governance and delegations of hospitals (3) Strengthen governance and delegation of districts	(1) Legislation to create NHI Fund – the NHI Bill introduction (2) Legislation amendments: (i) National Health Act; (ii) The Health Professions Act; (iii) General legislation amendment
Private sector	(1) High price for health services (2) Price regulation for all the services included in the NHI comprehensive benefits framework	(1) Introduction of single service benefits framework (2) Reduce the number of options per scheme	(1) Governance and non-health care (2) Reserves and solvency	(1) Medical Schemes Act and regulations reform

	Areas of operation			
Sector	**Financing**	**Provision**	**Governance**	**Regulatory**
	(3) Removal of differential pricing of services based on diagnosis. Copayments and balanced billing.	(3) Reform of PMBs and alignment to NHI services benefits, including common protocols/care pathways		(2) Consolidation: (i) consolidate GEMS and other state medical schemes into a single structure; (ii) reduce the number of medical schemes; (iii) reduce the number of options in medical schemes (3) Licensing of health establishments
Interim institutional structure			(1) Establishment of NHI transitional structures (2) Establishments of health system reform structures (3) Interim NHI fund	

Source: **https://businesstech.co.za/news/finance/487827/south-africa-prepares-for-next-phase-of-the-nhi-which-includes-mandatory-pre-payment/**

The National Health Act will result in the patient being viewed as a consumer from a legal perspective. Health care will be treated as a commodity, although this may result in the replacement of professional ethics with business ethics; this is evident from current practice in the private sector where doctors are paid on a fee-for-service basis. Some crooked doctors have been caught claiming from the medical insurance company more than once for a particular service rendered to a patient. Also, patients may abuse their autonomy by not following the doctor's advice given to them to help improve their health and this may lead to a waste of resources whereby the same ailment is treated repeatedly.

The NHI will be adopting a capitation method of payment which is based on the number of services offered by the doctor. This may motivate the doctor to over-service to generate more income, thereby becoming solely business-minded at the expense of their patients' health. To reach the target they set for themselves per day, the quality of health care that will be given to their patients may be poor, and this may lead to misdiagnosis and misinterpretation of patients' health complaints, which will result in poor health outcomes in the country. However, evidence from the implemented phase, as shown in Table 10.4, indicates that the programme is promising in terms of bringing South Africa closer to equality. Inequity in the private and public health services in terms of public health system burden, health care human resources, and financial disparities are beginning to fade, and patients now perceive an improvement in the quality of care as a result of the presence of general practitioners in the public sector. Aside from this, the operations in phase 1 in a way affect other SDGs, aside from aiming for universal health coverage. Objectives 5, 7, 8 and 9 also address SDG9, research and development, through advancing stock monitoring systems, clinical research and training, electronic patient record systems, and improving infrastructures.

A high level of organization and health service coordination is required to achieve the government's goal of a patient-centred, decentralized NHI. The time-consuming and extensive processes involved in NHI implementation, such as the allocation of financial and management authority in the DHS, must be taken into account. During the NHI's implementation, the restructuring of public health financing will be critical to its success. However, achieving NHI by 2026 may be impossible unless current and future challenges are addressed at the district level. In conclusion, NHI may not be the only solution to the inequality

Table 10.4 *Successes and challenges of NHI Phase 1 interventions*

Intervention	Intervention successes	Intervention challenges
WBPHCOTS	(1) In 2016/2017 a reported 3 519 WBPHCOTs covering 12 816 152 households (2) There was a total of 3 323 WBPHCOTs providing basic health services to children and adults at the end of 2017/2018 (3) These teams were able to successfully fulfill their mandate to provide outreach health services within the community (4) WBPHCOTs did not only complete community visits but they were also able to report on the ill-health or wellbeing of the individuals at the households visited	(1) Team composition was frequently insufficient, with several teams without outreach team leaders (2) The amount of data collected was insufficient to appropriately assess the referral systems and follow-up processes (3) There were occasions when there was insufficient funding for transportation and equipment, which hampered the team's ability to complete their work
ISHP	(1) A total of 4 339 875 learners had been screened through ISHP since 2012, of whom 504 803 were identified as having various health barriers and referred for treatment (2) This intervention is particularly successful in its ability to demonstrate good interdepartmental collaboration between the NDoH and the Department of Basic Education (DBE)	(1) There is a scarcity of data to back up the referrals' success, as well as feedback channels between school teams and facilities (2) Its success was frequently hampered by a lack of adequate equipment, such as measurement scales and transportation to schools (3) During NHI phase 1 execution, there was a lack of prioritization and targeting of learners within this intervention

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Table 10.4 *(Cont.)*

Intervention	Intervention successes	Intervention challenges
GP Contracting	(1) A total of 330 GPs had been contracted by end of 2017/2018 (2) Where contracting GPs was implemented successfully, it is evident that access to doctors improved at facilities (3) Patient perception was that the quality of care improved at facilities due to the presence of GPs	(1) Inadequate monitoring of these GPs caused some challenges during implementation (2) Unforeseen contractual challenges during the implementation of this intervention resulted in GPs having substantially higher expense claims than expected
ICRM	(1) A total of 3 434 facilities had been assessed and of these 1 507 had attained ideal clinic status at the end of 2017/2018 (2) ICRM is seen to have improved the ability of facilities to procure much-needed equipment (3) Where ICRM was believed to have been implemented as planned, there was a perceived improvement in the quality of care by both facility managers and patients (4) ICRM limited flexibility and the ability for managers to adapt it to the local context and to the needs of the facilities at the time	(1) The changing manual and frequent change of standards made it difficult for managers to keep up and resulted in frustration among them (2) ICRM offered limited flexibility and limited ability for managers to adapt it to the local context and the needs of the facilities at the time

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Table 10.4 *(Cont.)*

Intervention	Intervention successes	Intervention challenges
DCST	(1) At the end of March 2017, 45 of 52 districts in nine provinces had functional DCSTs with at least three members per team (2) The DCSTs, where available, were able to provide specialist oversight within the districts (3) The introduction of these teams was perceived by some stakeholders to have promoted clinical governance within the districts	(1) The team composition, which often lacked critical specialists, limited their ability to provide the envisioned training and support structures (2) The lack of gynaecologists and paediatricians meant that DCSTs were not able to adequately improve child and maternal health as envisioned (3) Not all specialists are necessarily good mentors and may be unable to provide adequate support (4) The DCST model is costly and stretches the limited specialist resources in the public sector
CCMDD	(1) A total of 2 182 422 patients enrolled on the CCMDD, collecting medicines in over 855 PUPs at the end of 2017/2018 (2) The strong political leadership and will behind CCMDD contributed to its successful implementation (3) CCMDD was scaled up beyond the target and the consistent monitoring of the programme contributed to the availability of reliable data to support continued implementation	(1) The change of service providers threatened the intervention's continuity (2) The lack of sufficient integration between CCMDD pick-up points and facilities resulted in inadequate tracking of patients between the two systems

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Table 10.4 *(Cont.)*

Intervention	Intervention successes	Intervention challenges
HPRS	(1) At the end of 2017/2018, 2 968 PHC facilities were using HPRS and there were over 20 million (20 700 149) people registered on the system (2) Good communication and feedback loops are seen to have facilitated implementation success	(1) Poor connectivity at some facilities and problems with hardware have contributed to the challenges experienced during NHI phase 1 implementation (2) The lack of human resources and lack of capacity to implement affected the success of HPRS
SVS	(1) At the end of 2017/2018, SVS was being implemented in 3 167 clinics and community health centres (92% coverage) (2) The successful training of available staff led to an in-depth understanding of the system at the facility level (3) The introduction of SVS led to reduced stockouts and improved efficiency at facilities	(1) Lack of reliable internet connectivity and hardware impacted its success (2) The minimal number of available pharmacists and pharmacy assistants limited the facility's ability to ensure the smooth running of the system (3) The sustainability of this intervention poses a challenge as implementation during the NHI phase1 relied heavily on support from external funders
Infrastructure	(1) Since 2013/2014, work in 139 of 140 identified CHCs and clinics has been completed through the NHI rehabilitation projects (2) In 2017/2018 alone, 107 facilities were maintained, repaired and/or refurbished in NHI districts (3) Where completed, patients perceived an improvement in the quality of care as a result (4) Small infrastructure changes had a positive impact on the overall environment at facilities	(1) Projects were rarely implemented or completed due to the lack of planning capacity to release the assigned funds (2) Funds that were released were used mainly for new infrastructure projects and 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

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Table 10.4 *(Cont.)*

Intervention	Intervention successes	Intervention challenges
Human Resources for Health	(1) The introduction of WISN provided a standardized, evidence-based staffing needs assessment at the facility level (2) These assessments were implemented widely across the pilot districts	(1) The resource-constrained environment meant that the 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 assessments

Source: Evaluation of phase 1 implementation of interventions in the National Health Insurance (NHI) pilot districts in South Africa. NDOH10/2017–2018 Final Evaluation Report July 2019

crises in South Africa. There are lots of situations to be tackled, such as unemployment, informal housing, family structure and education. NHI may reduce inequality and inequity in health care but largely the problem that needs to be solved is socioeconomic inequality given the social and economic disparities among the population groups in the country.

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