National Health Insurance
www.health.gov.za/nhi/

Invitation to brief the Standing Committee on Appropriations the funding model for the National Health insurance (NHI) and other matters

24 October 2025

health
Department:
Health
REPUBLIC OF SOUTH AFRICA

Phila
Inspired to live

2030
NDP

20 YEARS OF FREEDOM

Matters on Agenda

1. A detailed report on the department`s funding model for the National Health Insurance (NHI);
2. A Comprehensive Spending Plan on the recently received funding of $115 million Bridge Plan to sustain HIV prevention and treatment program;
3. A report on an aggregate analysis of healthcare service costs dispensed on undocumented foreign national;
4. Report on the department`s plans to fill key vacancies in senior positions in the healthcare facilities;
5. A detailed update on the department`s tracking and monitoring of its spending reviews;
6. Any other matter that will help the Committee to perform its oversight.

“What mischief are we trying to fix?”

United Nations (UN) and World Health Organisation (WHO) commitment to Universal Health Coverage (UHC):

Universal health coverage (UHC) means that **all people** have access to the **full range** of **quality health services** they **need, when and where they need them, without financial hardship**.

It covers the full continuum of essential health services, from health promotion to prevention, treatment, rehabilitation and palliative care across the life course.

THE SIX (6) BUILDING BLOCKS OF A HEALTHCARE SYSTEM

According to WHO (World Health Organisation) a health care system has six (6) building blocks:

1. **Leadership and governance;**
2. **Access to essential medicines and other commodities;**
3. **Health workforce (Human Resources)**
4. **Health systems financing**
5. **Health information systems**
6. **Health service delivery**

Declaration of Alma-Ata

International Conference on Primary Health Care, Alma-Ata, USSR, 6-12 September 1978

Declaration:

I

The Conference strongly reaffirms that health, which is a state of complete physical, mental and social wellbeing, and not merely the absence of disease or infirmity, is a fundamental human right and that the attainment of the highest possible level of health is a most important world-wide social goal whose realization requires the action of many other social and economic sectors in addition to the health sector.

II

The existing gross inequality in the health status of the people particularly between developed and developing countries as well as within countries is politically, socially and economically unacceptable and is, therefore, of common concern to all countries.

Three (3) Methods of Financing Health Care around the Globe

Forwarded

SA should ditch its American healthcare system

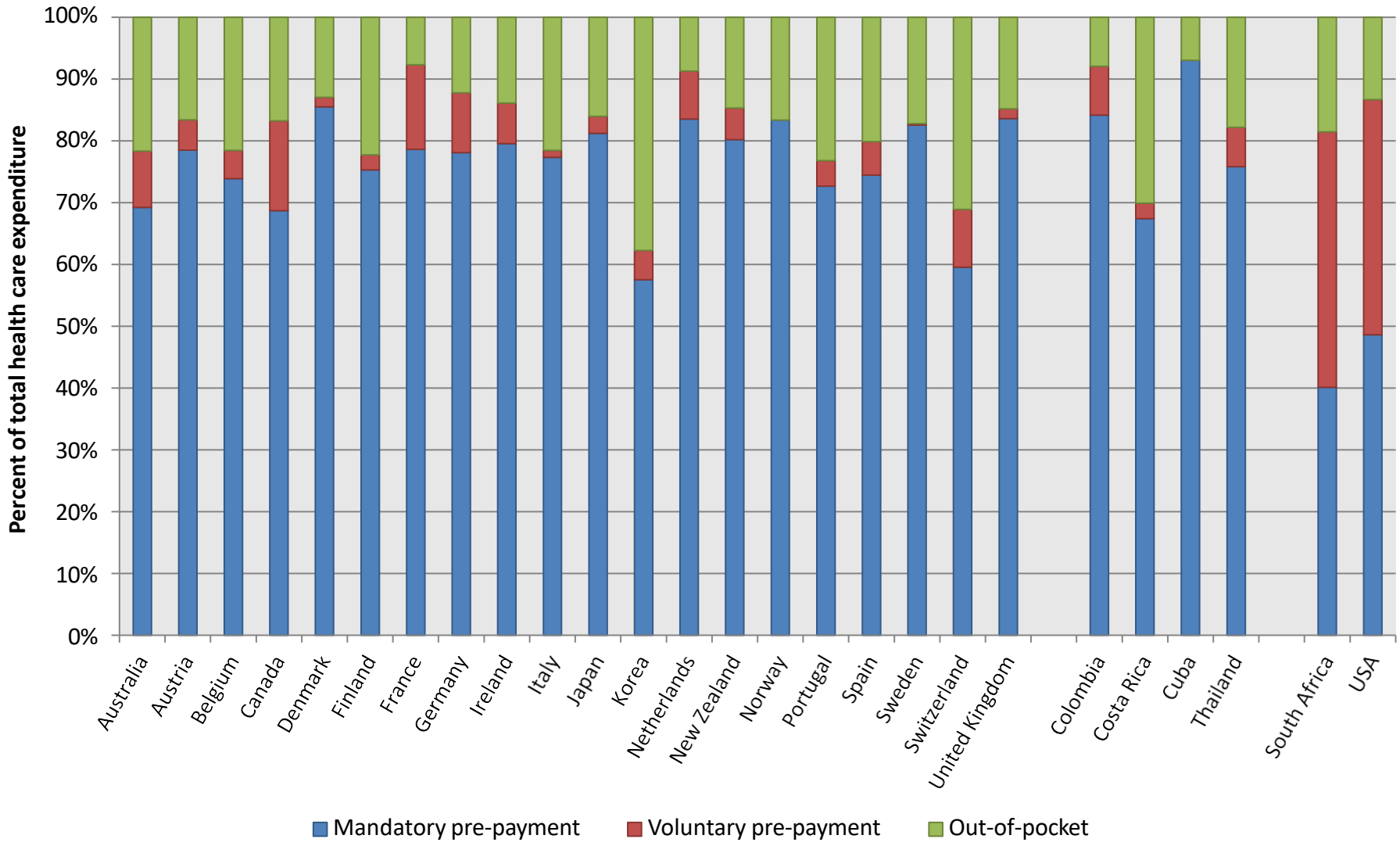
The rest of the world has learnt how to overcome the failings of the US healthcare system by replacing private health financing with public fina...

dailymaverick.co.za

https://www.dailymaverick.co.za/article/2025-05-22

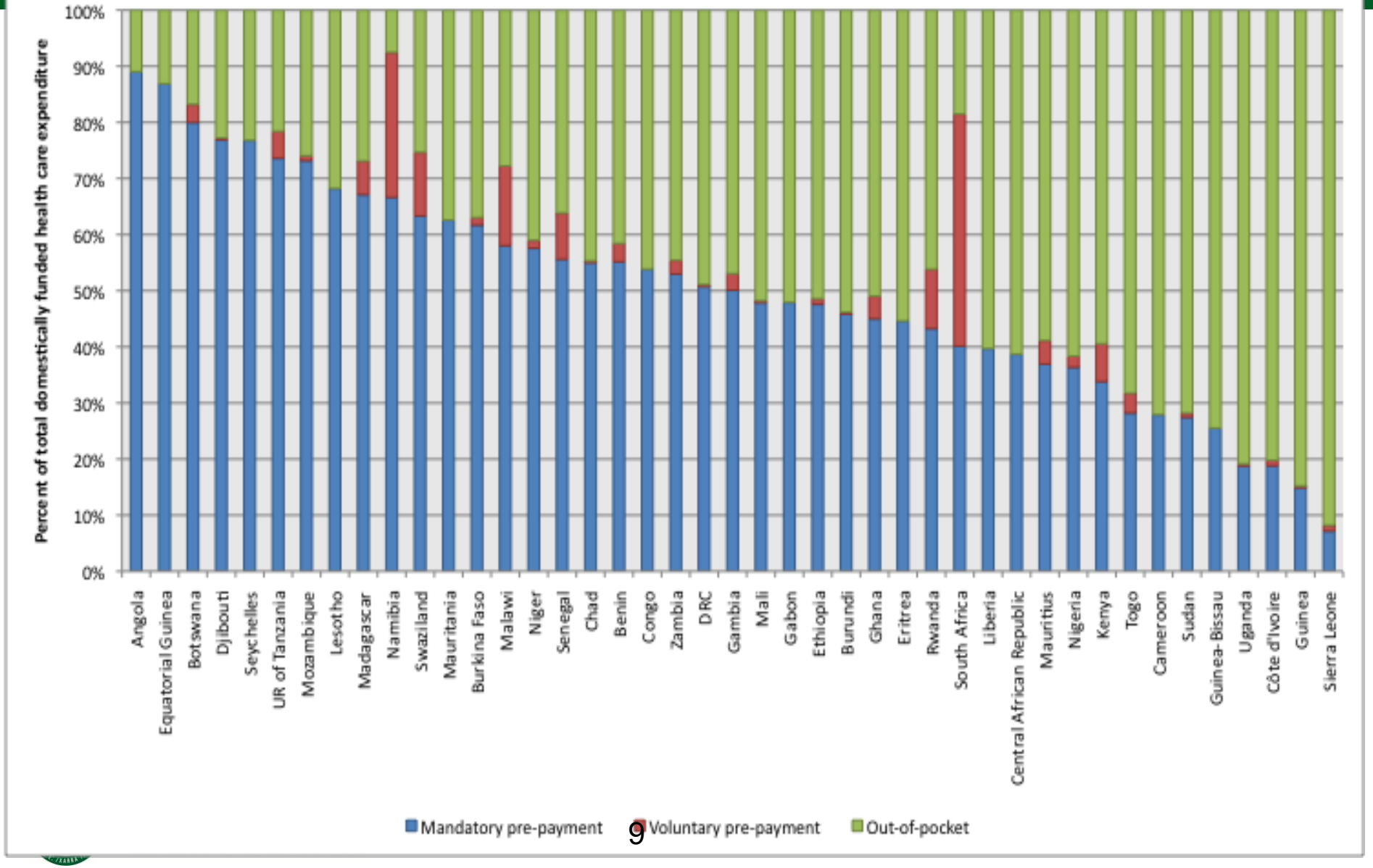
health
Department:
Health
REPUBLIC OF SOUTH AFRICA

National Health Accounts dataset



WHO National Health Accounts dataset (2009 data)

Africa – Disaster in the making



WORLD HEALTH ORGANISATION (WHO) RESPONSE

(UNIVERSAL HEALTH COVERAGE)

UHC

Examples of Countries with UHC

UK - NHS (National Health Service)

- 1948
- 2nd World War Crisis

Canada – Medicare

- 1947
- 2nd World War Crisis

Thailand – UHS (Universal Coverage Scheme) or 30-Baht Scheme

- 2002
- Asian Financial Crisis of 1997

Examples of Countries with UHC Contd.

– **Indonesia – JKN** (Jaminah Kasehata Nasional)
  - Year 2014
  - Asian Financial Crisis of 1997

– **Brazil – SUS** (Sistema Unico De Saude)
  - 1990
  - Very extremely high Gini Coefficient, poverty level at 25%
  - Now poverty level at 3.3%

– **China –** Resocialisation of its health financing system
  - 2002
  - SARS Crisis (Severe Acute Respiratory Syndrome Crisis)

Examples of Countries with UHC Contd.

- **Australia – Medicare**
- 1984
- "Before Medicare, we had a very ramshackle system. There was private health insurance, but it was very inefficient". Bill Bowtell, Chief of Staff for Minister Neal Blewett

- "Hundreds of thousands of Australians were not covered for medical treatment or hospital care. Hundreds of thousands of others could ill-afford the risings cost of private healthcare". The Age (Australian newspaper, 1 February 1984)

- "The new Medicare Programme will mean that 9 out of 10 Australians will pay less for the health needs of themselves and their families". Opposition Leader Bob Hawke, February 1983.

Examples of Countries with UHC Contd.

- **Mexico – Seguro Popular** (Popular Insurance for everybody
- 2001
- To reduce huge health disparities

- **USA – Obama Care** (Affordable Healthcare)
- Failed due to huge political opposition
- Huge interest groups in multipayer systems

Healthcare Financing

Recommendation from the WHO to the World:
5% of the GDP of a country to be spent on Health.

Where is South Africa?

8.5% of GDP spent on Health (presently R570 billion)

- 51% goes to 14% of the population
- 49% goes to 86% of the population

STATE SUBSIDY TO PRIVATE HEALTHCARE

1. Subsidy to Public Servants

- Teachers
- Doctors, Nurses and other healthcare workers
- Managers, including DGs, DDGs, HODs, Chief Directors, Directors, Deputy Directors and all other levels of public servants, CEOs and MDs of State Owned Enterprises and Public Entities
- The Police
- The Army
- The Judiciary
- The President, Deputy President, Members of Parliament and of Provincial Legislatures, including Ministers, Deputy Ministers, Premiers, MECs,

  - **R70 billion**

- **2. Tax Rebates / Credits:**

  - **R33 billion**

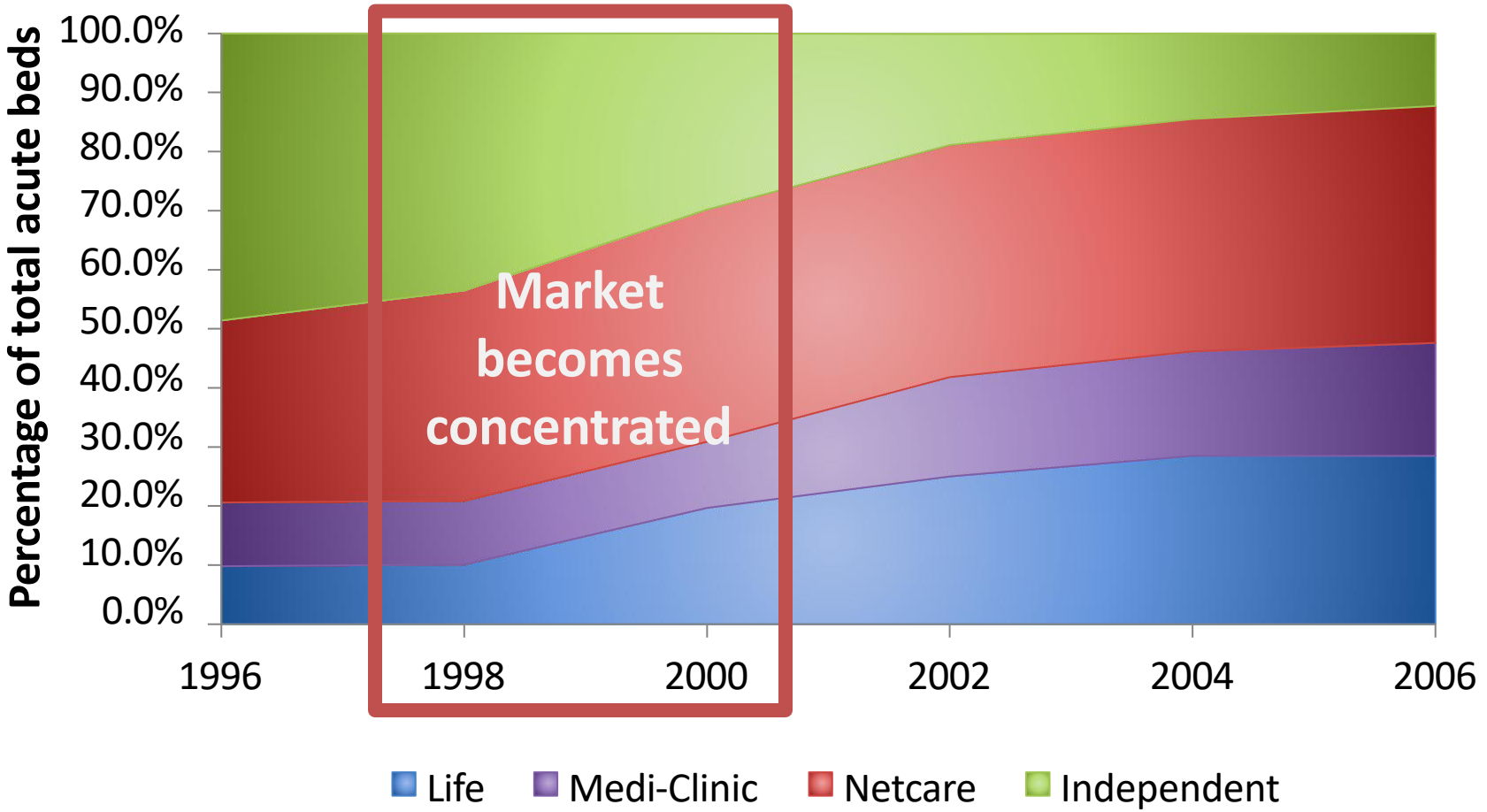
Selected Health Statistics, BRICS Countries

Indicator	Brazil	Russian Federation	India	China	South Africa
Total population (millions)	215.3	143.9	1442.6	1474.0	63.1
Total expenditure per capita (PPP int $)	1,625	1,600	1,100	1,700	1,700
Total expenditure on health as % of GDP	9.89	7.6	3.28	6.8	8.5
General government expenditure on health as % of total government expenditure	10.1	12	6.5	7.5	13.5
Life expectancy at Birth Males Females Both	 73.07 79.26 76.7	 69.57 79.29 74.5	 70.52 73.65 72.03	 76.18 81.52 77.0	 61.4 67.3 64.3

health
Department:
Health
REPUBLIC OF SOUTH AFRICA

Indicator	Brazil	Russian Federation	India	China	South Africa
Infant mortality rate (per 1,000 live births)	12.4	4.64	25.79	8.17	27.7
Under 5 mortality (per 1,000 live births)	12.4	5.8	29.1	8.1	28
Adult mortality rates, 15-59 years (per 1,000 population)					
Male	205	391	250	142	521
Female	102	144	169	87	479
Both	154	269	212	116	496
Maternal Mortality Ration (per 100,00 live births)	55	23	97	23	119
Distribution of years of life lost by causes (%)					
Communicable	12.1	6.3	14.1	14.1	37.4
Non Communicable	34.6	53.4	31.4	43.8	24.9
Injuries	34.6	34.1	29.4	25.6	23.1
Prevalence of HIV among adults aged 15-49 (%)	0.6	1.0	0.3	0.1	12.7
Prevalence of TB (per 100,000 population)	48	47	192	61	781
Tobacco smoking 15+ (%)					
Males	22.4	39.1	19.9	48.4	41.7
Females	14.5	21.7	2.0	2.3	17.9

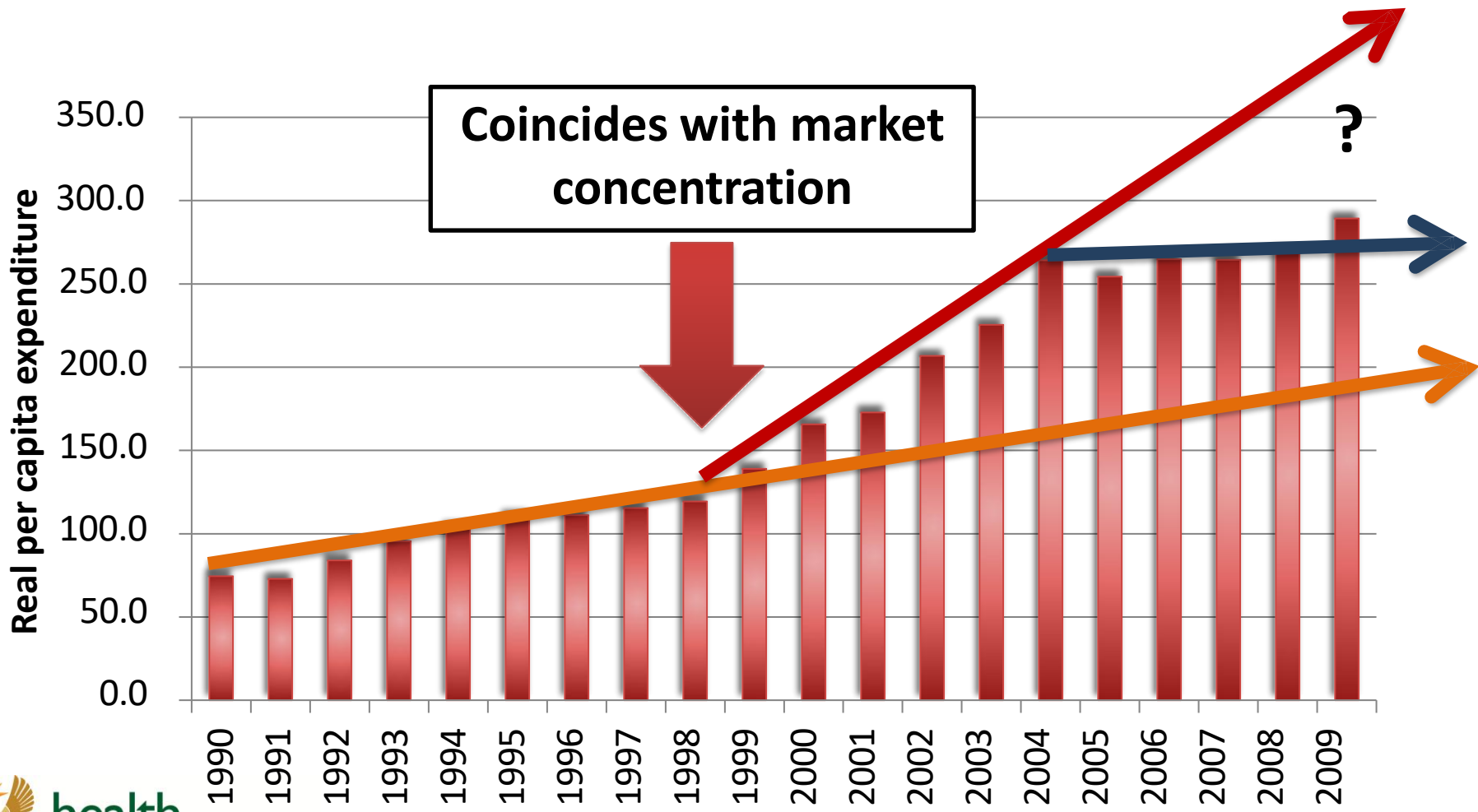
The private hospital market in metropolitan areas (50%+ of medical scheme population) was concentrated by 1999



Only 12.3% of private hospital beds were outside three main hospital groups by 2006…

health
Department:
Health
REPUBLIC OF SOUTH AFRICA

PRIVATE HOSPITAL REAL COST TRENDS (2009 PRICES)



health
Department:
Health
REPUBLIC OF SOUTH AFRICA

Racial divide in healthcare use

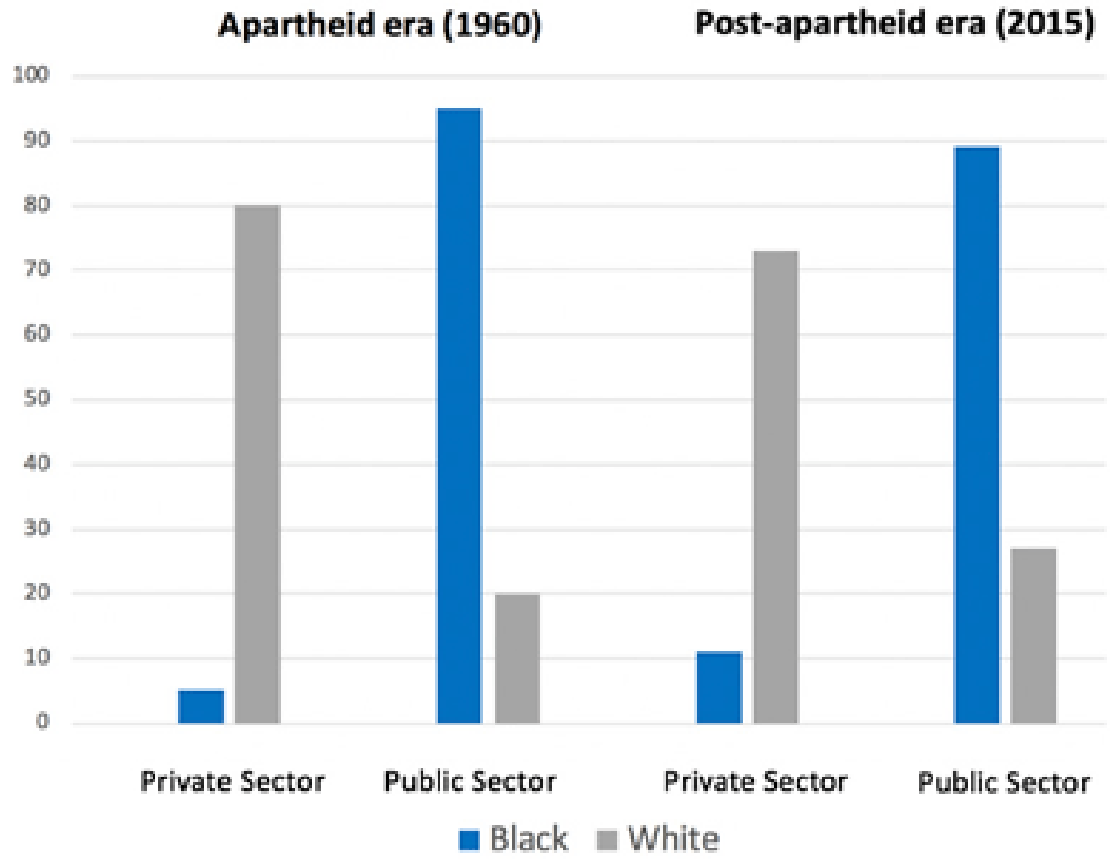


Figure 1. Private and public sector users by race

Percentage of the black and white South African population using private or public services (2017)

Source: *Solomon et al. A Health Care System Divided: How Apartheid's Lingering Effects Harm South African Maternal Health. McGill Journal of Global Health. 2020;9(1):27-44.*

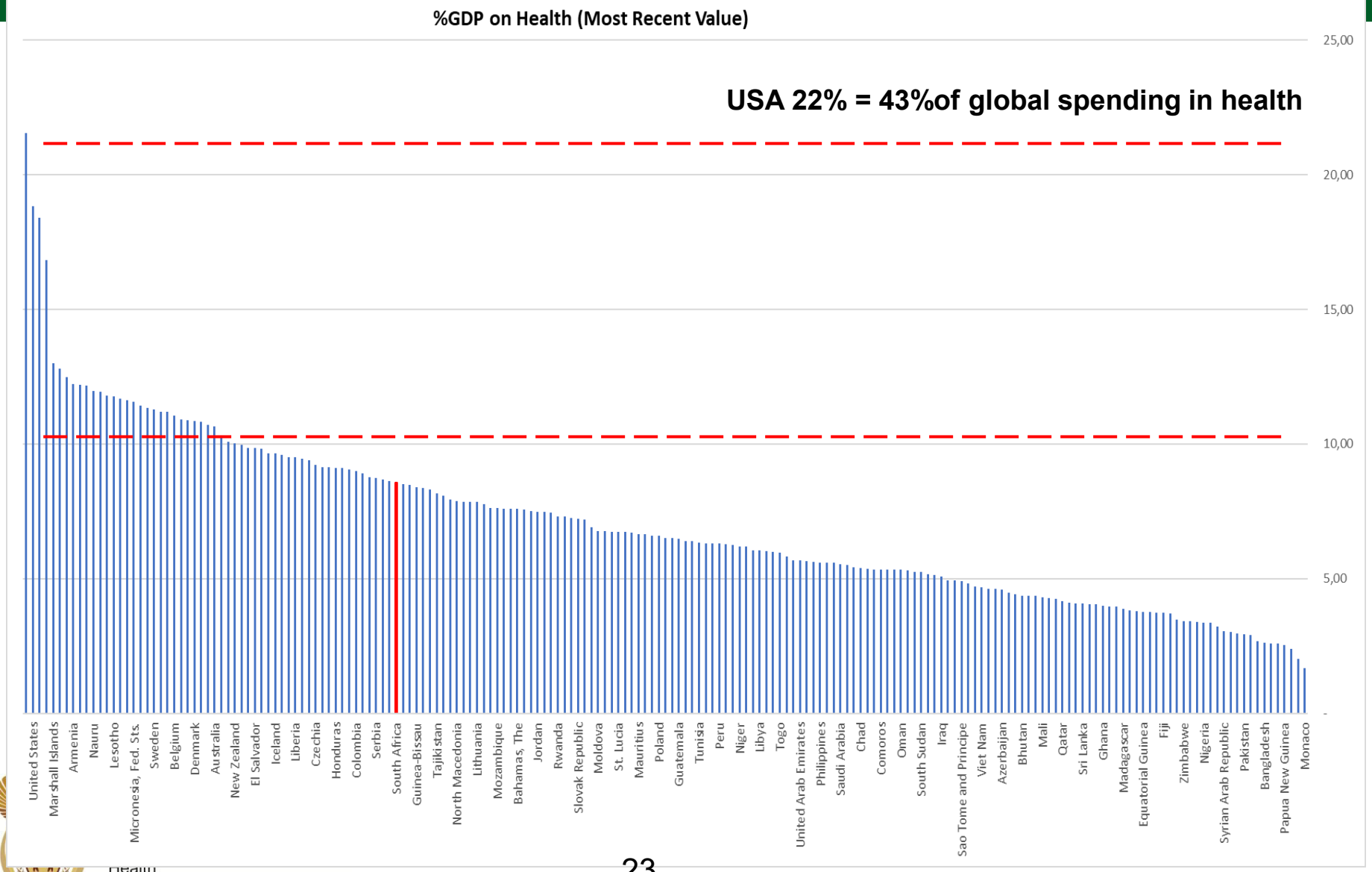
health
Department:
Health
REPUBLIC OF SOUTH AFRICA

Racial Divide Translates into: (for over a half century of MEDICAL AIDS)

- Covers only 10% of the black population
- But covers 72% of the white population

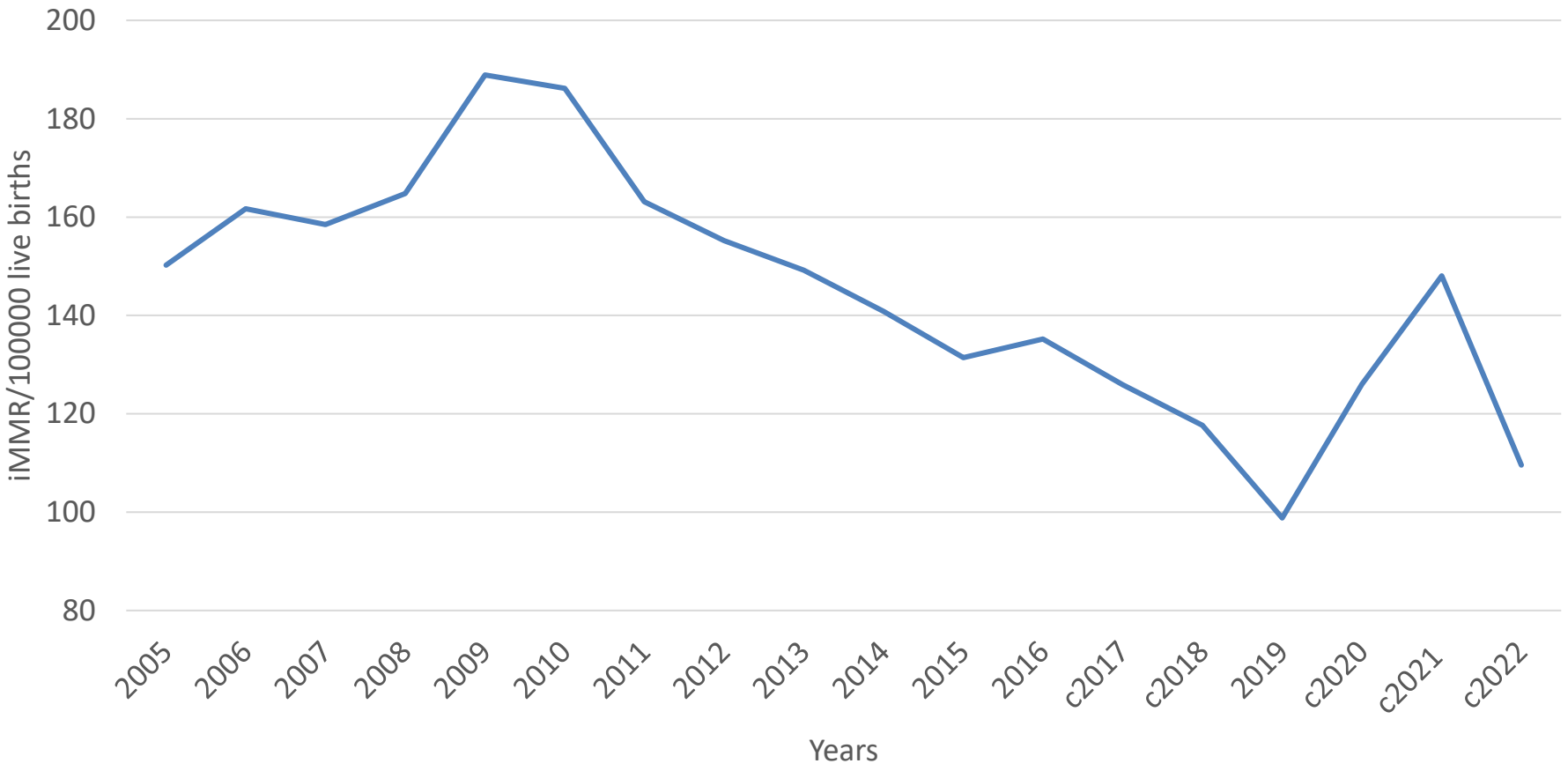
- This means that 90% of the black population remains uncovered and 28% of the white population also remains uncovered

World Bank Report %GDP on Health



Is there an example of what NHI can achieve?

Trends in iMMR in SA 2005 to 2022



health
Department:
Health
REPUBLIC OF SOUTH AFRICA

The graph depicts the NHI Type of Practice –

Massive Universal HIV/AIDS Counselling, Testing and Treatment Campaign of 2010, dramatically brought down maternal mortality in the country.

Can the Healthcare system survive the present health financing situation?

Main issue under contention

Multipayer system vs Single payer system

The DA, Big Business, Huge Sections of the Media with a few exceptions, Some doctors, insisting on multi-payer system, as against Single Payer System which the Act envisages

1. **A detailed report on the department`s funding model for the National Health Insurance (NHI)**

1. Detailed report and an update on NHI funding

- National Health Insurance Act (NHI), 2023 (Act No. 20 of 2023)
- Two sections deal with the Funding (**s48 and s49**)
- But the rest of the Act explains what the Fund must pay for and how

Sources of funding

48. The revenue sources for the Fund consist of—

*(a) money to which the Fund is **entitled in terms of section 49**;*

*(b) any **interest or return on investment** made by the Fund;*

(c) any money paid erroneously to the Fund which, in the opinion of the Minister, cannot be refunded;

(d) any bequest or donation received by the Fund; and

(e) any other money to which the Fund may become legally entitled.

NHI funding - Chief source of income (s49)

*49. (1) The Fund is entitled to money **appropriated annually by Parliament** in order to achieve the purpose of the Act.*

(2) The money referred to in subsection (1) must be—

*(a) appropriated **from money collected and in accordance with social solidarity** in respect of—*

*(i) general tax revenue, including the **shifting of funds** from national government departments and agencies and the provincial equitable share and conditional grants into the Fund;*

*(ii) reallocation of funding for **medical scheme tax credits** paid to various medical schemes towards the funding of National Health Insurance;*

*(iii) **payroll tax** (employer and employee); and*

*(iv) **surcharge** on personal income tax,*

***introduced through a money Bill by the Minister of Finance and earmarked for use by the Fund,** subject to section 57; and*

(b) calculated in accordance with the estimates of income and expenditure as contemplated in section 53 of the Public Finance Management Act.

*(3) Once appropriated, the revenue allocated to the Fund must be **paid through a Budget Vote to the Fund** as determined by agreement between the Fund and the Minister and subject to the provisions of the Constitution and the Public Finance Management Act.*

The appropriated money must pay for :

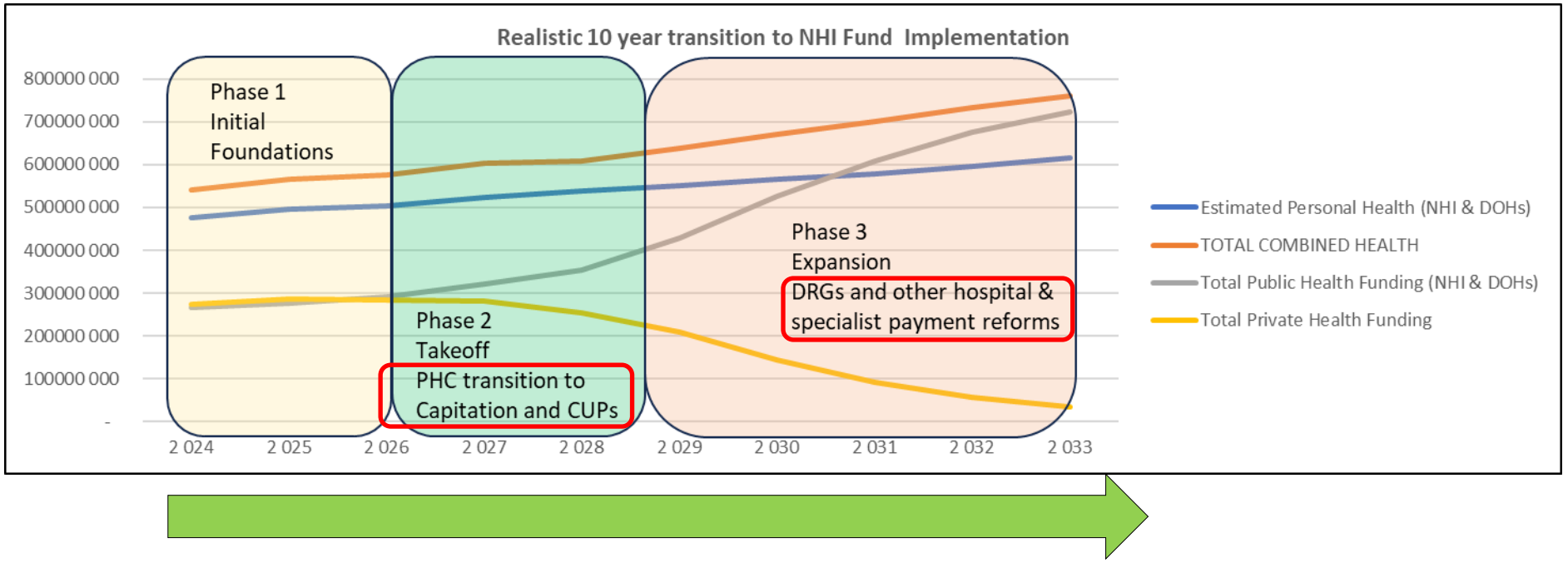
The NHI Fund must pay for Benefits and its own administration from appropriated funds

- **Benefits** that NHI Fund is mandated to **pay** health care providers (>98%)
  - public and private providers
  - **'comprehensive'** [**does not mean everything** (see s7(4) for exclusions]

    *"health care services that are managed so as to ensure a **continuum** of **health promotion, disease prevention, diagnosis, treatment and management, rehabilitation and palliative care** services **across the different levels and sites of care** within the **health system** in accordance with the needs of users*
  - Primary care, nursing care, specialist care and supporting health professionals
- **Administrative costs** of managing the functions of the Fund (s10) (<2%)
  - User registration and management
  - Provider accreditation and contracting
  - Development and maintenance of the benefits and their pricing
  - Health products (formulary of medicines and devices)
  - Digital systems
  - Risk and fraud management
  - Banking and payment management
  - Corporate services

Transition to 'full' NHI Fund benefits funding

Illustrative (10 yr, 15 yr, or more)



Transition to 'full' NHI Fund benefits funding

Year

Vehicle

Current funding source

Conditions necessary

Source value 2024/25

Amounts shifted or added in Appropriation Year

ILLUSTRATIVE PHASING IN OF FUNDING CHANGES AND INDICATIVE AMOUNTS (2023 RAND)

	YEAR 0	YEAR 1	YEAR 2	YEAR 3	YEAR 4	YEAR 5	YEAR 6	YEAR 7	YEAR 8	YEAR 9	YEAR 10	YEAR 11	YEAR 12	YEAR 13	YEAR 14
YEAR	**FY2023/24**	**FY2024/25**	**FY2025/26**	**FY2026/27**	**FY2027/28**	**FY2028/29**	**FY2029/30**	**FY2030/31**	**FY2031/32**	**FY2032/33**	**FY2033/34**	**FY2034/35**	**FY2035/36**	**FY2036/37**	**FY2037/38**
VEHICLE	**NDOH Branch**				**PFMA Schedule 3A entity**										
SOURCE OF FUNDS FOR NHI FUNCTIONS	**NDOH Indirect Conditional Grants**			**NDOH Direct Conditional Grants**	**PDOH Provincial Equitable Share**						**Medical schemes (Employer contribution private employer)**				
Statutory changes to effect fund shift	Requires no statutory amendment			Requires statutory amendment in MTBPS/DORA to convert to Indirect (funds follow the function)	Requires s32 of NHI Act followed by statutory amendment in MTBPS/DORA Quantification of which funds to move depend on capacity to administer (Capitation, DRG, etc) Funds will follow shifted functions						Requires s33 of the NHI Act followed by statutory amendments in MSA				
Other prerequisites	•Develop content, rules and systems •User management •Prov... and proc... •Ben... •Health product procurement ... systems •Digital support systems •Fund integrity (risk management and fraud/corruption management mechanisms) •Plan the phases carefully and document the processes at conceptual level CUP development and first implementation			Plan the phase carefully and document the processes at detailed level (See NDOH document on Conditional Grant Reforms) •**NHI Direct Grant** (separate Infrastucture Grant out which must be centralised to NDOH) •**NHI Indirect Grant** (already in NDOH but very small - CUP proof of concept) •**National Tertiary Services Grant** (central hospital Boards must be in place, costing of each and readiness assessment) •**Human Resources & Training Grant** (formal policy and centralise planning) Costing of posts paid •**District Health Programmes Grant** (CUPs must be in place and capitation payment systems working)		Plan the phase carefully and document the processes at detailed level (eg start to shift ONLY PHC service provision funding)	During this period there need to be systematic shifts of the PES * Costs centres at Hospitals * Delegated managerial authority (autonomy) * DHMOs in place * Private hospital accreditation and contracting					Plan the phases carefully and document and implement the processes at implementation level Will need to raise taxes for the portion of the money that is not already shifted in the system Must be clear on the benefits that NHI is paying for and what is left to the schemes				
SOURCE OF FUNDS FOR NHI FUNCTIONS				**Tax credits**			**Medical schemes (Employer contribution public service and entities)**				**Medical schemes (Employee contribution)**				
Statutory changes to effect fund shift				Systematically reduce tax credits and collect the fiunds for the public sector (probably over 3 years) - Treasury policy in MTBPS (requires NHI Act followed by statutory amendment in Tax laws)							(requires NHI Act followed by statutory amendment in MSA)				
SOURCE OF FUNDS FOR NHI FUNCTIONS						**Correctional Services**		**Workmen's Compensation contributions**			**Out of pocket**				
Statutory changes to effect fund shift						(requires NHI Act followed by statutory amendment in MTBPS/DORA)		Requires NHI Act followed by statutory amendment in WCA Quantification of hospital benefits portion of budget			(requires NHI Act followed by statutory amendment in Tax laws)				
SOURCE OF FUNDS FOR NHI FUNCTIONS				**Medical insurance**				**Road Accident Fund levies**							
Statutory changes to effect fund shift				Requires no statutory amendments but phasing out of the MSA exemptions (target was March 2024 - need to acce...				(requires NHI Act followed by statutory amendment in RAF Act)							
POTENTIAL FUND AMOUNTS ('000s) 2023 nominal	**1 629 000**	**1 629 000**	**1 629 000**				**...8 676 000**	**307 676 000**	**307 676 000**	**307 676 000**	**443 776 000**	**443 876 000**	**443 876 000**	**457 876 000**	**457 876 000**
Operational budget	850 000	850 000	850 000				1 000 000	1 000 000	1 000 000	1 000 000	1 100 000	1 200 000	1 200 000	1 200 000	1 200 000
NHI Direct Grant	694 000	694 000	694 000	694 000	694 000	694 000	694 000	694 000	694 000	694 000	694 000	694 000	694 000	694 000	694 000
NHI Indierct Grant	85 000	85 000	85 000	85 000	85 000	85 000	85 000	85 000	85 000	85 000	85 000	85 000	85 000	85 000	85 000
NTSG					14 300 000	14 300 000	14 300 000	14 300 000	14 300 000	14 300 000	14 300 000	14 300 000	14 300 000	14 300 000	14 300 000
HR&TG					5 400 000	5 400 000	5 400 000	5 400 000	5 400 000	5 400 000	5 400 000	5 400 000	5 400 000	5 400 000	5 400 000
DH Prog Grants					26 981 000	26 981 000	26 981 000	26 981 000	26 981 000	26 981 000	26 981 000	26 981 000	26 981 000	26 981 000	26 981 000
Correctional Services					1 216 000	1 216 000	1 216 000	1 216 000	1 216 000	1 216 000	1 216 000	1 216 000	1 216 000	1 216 000	1 216 000
State contribution to reserves															
PES					75 000 000	75 000 000	105 000 000	150 000 000	150 000 000	150 000 000	150 000 000	150 000 000	150 000 000	150 000 000	150 000 000
WCA								2 800 000	2 800 000	2 800 000	2 800 000	2 800 000	2 800 000	2 800 000	2 800 000
RAF								1 200 000	1 200 000	1 200 000	1 200 000	1 200 000	1 200 000	1 200 000	1 200 000
Public sector employer contributions							70 000 000	70 000 000	70 000 000	70 000 000	70 000 000	70 000 000	70 000 000	70 000 000	70 000 000
New Taxes											136 000 000	136 000 000	136 000 000	150 000 000	150 000 000
Tax credits				11 333 333	34 000 000	34 000 000	34 000 000	34 000 000	34 000 000	34 000 000	34 000 000	34 000 000	34 000 000	34 000 000	34 000 000

Constraints and opportunities

- There is resistance to change – complex and threatening
- Section 49 is misunderstood and misinterpreted
- Opponents create the narrative that everything will happen at once and 'break the existing arrangements'
- Slow economic growth means no 'new' money so any change must wait or be paid from efficiency gains
- Existing conditional grants can be used if we are allowed to consolidate and change the frameworks (must be 'indirect')
- Slow removal of medical tax credits offer a source of funding if it is earmarked (into a separate fund for developing NHI)
- Thresholds for systematic withdrawal of medical tax credits have been estimated by Treasury and there are options

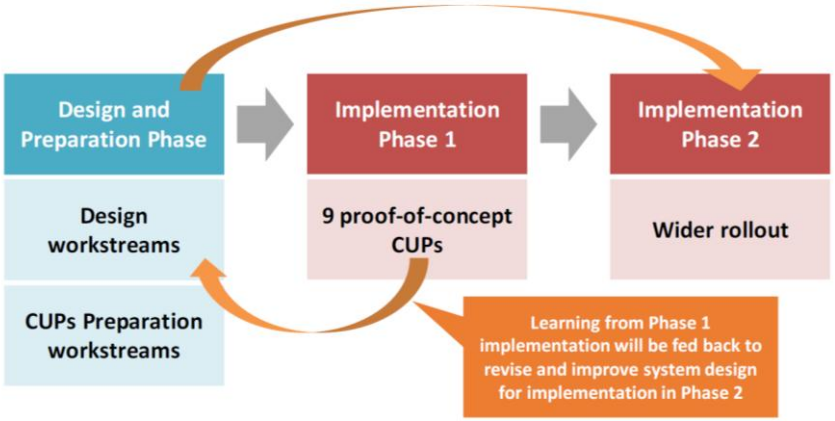
2. Additional resources that will be required for the implementation of the NHI

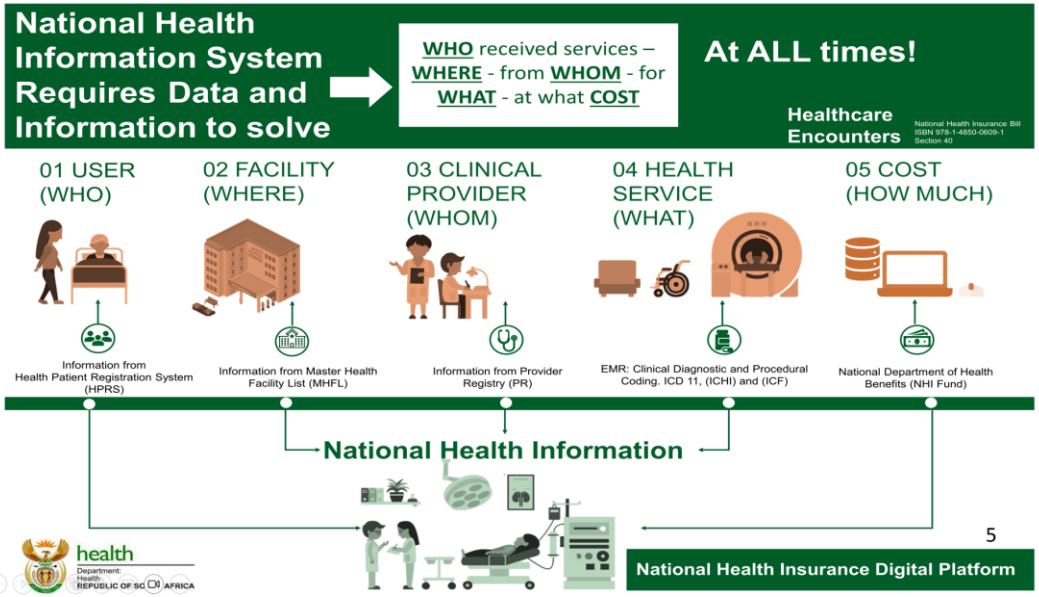
- No additional resources are needed to pay benefits (core business of the NHI Fund)
- Section 49(2)(a)(i) speaks of “shifting of funds” into the Fund
  - national government departments (eg Correctional Services in due course)
  - agencies (like the health benefits portion of RAF, Compensation)
  - provincial equitable share (in due course once s32 is implemented with s25 amendments of the National Health Act (NHA) as already adopted in Schedule 1)
  - conditional grants
    - systematic and not all at once
    - Indirect grants and earmarked funds consolidated
    - Direct grants for patient care as the services are NHI paid, so PHC first
- Funds are required to establish the capability of the Fund (entity)
  - Business case was first submitted in 2019 and twice updated (latest 2025)
  - Detailed costing has been done to gear up over 3 years
  - Organogram 260 staff rising to 400 (present massive dependence on donors)
  - Goods & Services, Capital (plus digital rollout in provinces), etc costed
  - R500m rising to R700m operational and capital requirement

3. Report on the list of 'trial sites' (healthcare facilities) that are identified for the implementation of NHI

- **Contracting Units for Primary Health Care (CUPs)**
- S37 of the NHI Act
- Section 57 Transitional Arrangements
- Integrated systems implementation

Figure 1: Phases of CUPs model rollout





NHI CUPS PROGRAMME

CUPS PROGRAMME PROJECT PLAN - 2024/25

CUPs Proof-of-Concept: 9 identified sites

Province	District	CUP	Number of Facilities (155)
Gauteng	Johannesburg MM	Johannesburg D (Soweto)	29
KwaZulu Natal	uMzinyathi	Nguthu	15
Limpopo	Waterberg	Thabazimbi	10
North West	Ngaka Modiri Molema	Mahikeng	15
Mpumalanga	Nkangala	Steve Chwete	29
Free State	Thabo Mofutsanyana	Dihlabeng	11
Western Cape	Garden Route and Central Karoo Districts	Knysna & Bitou	17
Eastern Cape	OR Tambo DM	Ingquza Hill LM	21
Northern Cape	Francis Baard	Phokwane	8

2. **A Comprehensive Spending Plan on the recently received funding of $115 million Bridge Plan to sustain HIV prevention and treatment program**

BACKGROUND

- PEPFAR funded South Africa through Country Operation Plan (COP 25), with Centers for Disease Control and Prevention (CDC) and United States Agency for International Development (USAID) being Implementing Agencies
- The support was mainly on scale up, direct service delivery, and health system strengthening excluding procurement of drugs.
- Executive Orders were issued by President Trump on 29 January 2025.
- Both USAID and CDC agencies paused all work supported by PEPFAR in the 27 Districts
- USAID funding was terminated resulting to job losses for 8 457 staff.
- On 17 February 2025 CDC resumed work fully until September 2025, at the end of contract PEPFAR sent a letter to the Department stating continuation of services for 6 months and thereafter a new plan will be shared

BACKGROUND

On the 6th October 2025, the Minister received a letter on the Approval of PEPFAR Bridge Plan (PBP) for South Africa, which states the following:

- The PEPFAR Bridge Plan will ensure uninterrupted HIV Service Delivery from 1 October 2025 - 31 March 2026 (6 months)
- South Africa's budget for The PEPFAR Bridge Plan is approved at $115 million, to be used to support core services which are aligned to the *Limited Waiver to Pause of US Foreign Assistance for Life- saving HIV Service Provision,* released in February 2025.
- The PEPFAR Bridge Plan will focus on service continuity with minimal program changes, prioritizing country-specific needs and life-saving impact.

- The implementation arrangement is that PEPFAR allocates the budget to CDC as an Implementing Agent
- CDC appoints implementing partners in Provinces. The budgets are allocated to the Implementing partners.
- Therefore the National Department of Health cannot account for spending plan of this $115 million
- The Department is meeting with PEPFAR and CDC to look at the plans being developed and ensure alignment with the countries priorities
- On 22 October 2025, PEPFAR sent a generic plan, indicating that Implementing Partners were finalising work plans with the Provinces.

PEPFAR BRIDGE PLAN - ACTIVITIES

On **22 October 2025**, PEPFAR sent a generic plan, indicating that Implementing Partners were finalising work plans with the Provinces. This plan included the following activities:

Interventions	
National Support (DSD and DoH)	Support for the operations, maintenance, and use of current facility and community, and national data systems (including paper and electronic record systems) necessary for patient management and program monitoring in the provision of the services covered in the PEPFAR waiver
HIV Testing Services for ALL Populations (For HIV Case Finding, Re-entry in Care, and PMTCT)	Provision of HIV testing in community and facility settings (including PICT, HIVSS, index testing, confirmatory testing)
	HIV Screening for People Diagnosed with TB
	All PMTCT and HIV exposed infant (HEI) related testing
	Procurement and distribution of HIV test kits, including HIV self-test kits, and referral/follow-up for confirmatory testing and ART for those who test positive
	Supply chain support for HIV testing commodities and lab commodities needed to support HIV testing

PEPFAR BRIDGE PLAN - ACTIVITIES

Interventions	
HIV Care and Treatment Services for ALL PLHIV	Provision of HIV drugs and support to prevent treatment interruptions for adults and children in community and facility setting
	Provision of care for advanced HIV disease, including CD4 testing (immune function test), prevention and treatment of opportunistic infections, and HIV treatment adherence support.
	Provision of HIV viral load testing, which allows patient monitoring to ensure that HIV drug treatments are effective
	Specific components of HIV care and treatment that should be supported
Laboratory Support	Laboratory related support at facility level
Supply Chain Management	Procurement of HIV medicines and commodities (support role only) (Note: MatCH does not procure directly, but supports oversight and monitoring to prevent stockouts through employed Pharmacists)
Paediatric and Adolescent Specific Considerations	Paediatric or adolescent specific case finding and care and treatment activities
PMTCT and HIV-Exposed Infants Specific Considerations	Prevention of Mother-to-Child Transmission of HIV, which consists of testing and re-testing pregnant and breastfeeding women and HIV treatment drugs for pregnant and breasetfeeding women who are positive HIV testing partners early infants diagnosis and comprehensive care for infants

PEPFAR BRIDGE PLAN - ACTIVITIES

Interventions	
Advanced HIV Disease - (Prevention and Treatment of Opportunistic Infections)	Advanced HIV Disease – [Prevention and Treatment of Opportunistic Infections] Life-saving HIV care and treatment services, inclusive of HIV testing and counseling, and prevention and treatment of opportunistic infections including TB & Laboratory Services
HIV Pre-exposure Prophylaxis (PrEP) prioritized for pregnant and breastfeeding women (PBFW) , and other at-risk populations	HIV Pre-exposure Prophylaxis (PrEP): Pre-exposure prophylaxis (PrEP) should be offered should be priortitzed for pregnant and breastfeeding PBFW and then for other at-risk populations; they may receive either oral or long-acting PrEP.
TB Prevention, Diagnosis and Treatment for PLHIV	TB Prevention, Diagnosis, and Treatment for PLHIV
Strategic Information / Informatics	Support for Country Data Systems

PEPFAR BRIDGE PLAN – GEOGRAPHIC COVERAGE

Program Area	Province	Districts / Areas Covered	Number of Facilities / Districts	Implementing Partner(s)
DSP Services	Eastern Cape	Buffalo City, Alfred Nzo, Oliver Tambo, Chris Hani, Amathole	666 (MatCH: 165; TB HIV Care: 491)	MatCH, TB HIV Care
	Gauteng	City of Tshwane, Ekurhuleni	202 (WRHI: 183)	WRHI
	KwaZulu-Natal	eThekwini, uMgungundlovu, Ugu, Harry Gwala, King Cetshwayo, uThukela, Zululand	631 (MatCH: 218; HST: 384)	MatCH, HST
	North West	Ngaka Modiri Molema, Dr Kenneth Kaunda, Bojanala Platinum	324 (Aurum: 316)	Aurum
Correctional Services	Eastern Cape	Various correctional centres	11	Not listed
	Free State	Various correctional centres	8	Not listed
	Gauteng	Various correctional centres	17	Not listed
	KwaZulu-Natal	Various correctional centres	18	Not listed
	Limpopo	Various correctional centres	6	Not listed
	Mpumalanga	Various correctional centres	6	Not listed
	Northern Cape	Various correctional centres	2	Not listed
	North West	Various correctional centres	6	Not listed
	Western Cape	Various correctional centres	14	Not listed
OVC (Orphans & Vulnerable Children)	Eastern Cape	Chris Hani, Amathole, OR Tambo	5 districts	MatCH, PACT
	Gauteng	City of Johannesburg, Sedibeng, City of Tshwane	3 districts	PACT
	KwaZulu-Natal	Ugu, King Cetshwayo, uMgungundlovu, Harry Gwala, eThekwini, uThukela, Zululand	7 districts	PACT
	Limpopo	Capricorn, Mopani	2 districts	PACT
	Mpumalanga	Gert Sibande, Ehlanzeni, Nkangala	3 districts	PACT
	North West	Bojanala, Ngaka Modiri Molema, Dr Kenneth Kaunda	3 districts	PACT

PEPFAR BRIDGE PLAN – BUDGET

Province / Level	District / Metropolitan Municipality	Budget (USD)
Above-site Support		$25,575,823
National Support	Department of Health (DoH), Department of Social Development (DSD)	$4,050,000

Province / Level	District / Metropolitan Municipality	Budget (USD)
KwaZulu-Natal	Amajuba	$86,433
	eThekwini	$6,677,678
	Harry Gwala	$2,507,714
	King Cetshwayo	$4,354,409
	Ugu	$3,523,603
	uMgungundlovu	$2,716,530
	Umzinyathi	$3,766
	Uthukela	$1,675,436
	Zululand	$2,053,823
	Total	**$23,599,393**

- NOTE: The budget detailed in these tables is as submitted by PEPFAR to NDoH on 22 October 2025. It adds up to a **total of $106,253,232**
- This is **different from the total of $115 million which is referred to in the PEPFAR letter** – the difference must still be discussed with PEPFAR to understand

PEPFAR BRIDGE PLAN – BUDGET

Province / Level	District / Metropolitan Municipality	Budget (USD)
Gauteng	City of Johannesburg	$2,256,122
	City of Tshwane	$7,316,227
	Ekurhuleni	$8,333,759
	Sedibeng	$510,365
	Total	**$18,416,473**
Mpumalanga	Ehlanzeni	$2,267,006
	Gert Sibande	$606,269
	Nkangala	$598,822
	Total	**$3,472,097**

Province / Level	District / Metropolitan Municipality	Budget (USD)
North West	Bojanala Platinum	$5,103,836
	Dr Kenneth Kaunda	$2,558,671
	Ngaka Modiri Molema	$2,604,473
	Total	**$10,266,980**
Limpopo	Capricorn	$495,643
	Mopani	$477,190
	Vhembe	$83,018
	Waterberg	$19,424
	Total	**$1,075,275**

PEPFAR BRIDGE PLAN – BUDGET

Province / Level	District / Metropolitan Municipality	Budget (USD)
Free State	Fezile Dabi	$37,892
	Lejweleputswa	$35,237
	Mangaung	$47,168
	Xhariep	$4,077
	Total	**$124,373**
Northern Cape	—	**$54,457**

Province / Level	District / Metropolitan Municipality	Budget (USD)
Western Cape	Cape Winelands	$44,014
	City of Cape Town	$1,632,706
	Garden Route	$14,441
	Overberg	$27,772
	West Coast	$48,404
	Total	**$1,767,337**

PEPFAR BRIDGE PLAN – BUDGET

Province / Level	District / Metropolitan Municipality	Budget (USD)
Eastern Cape	Alfred Nzo	$4,637,711
	Amathole	$2,073,058
	Buffalo City	$4,389,110
	Chris Hani	$2,437,440
	Nelson Mandela Bay	$69,734
	Oliver Tambo	$4,225,100
	Sarah Baartman	$18,870
	Total	**$17,851,024**

TOTAL BUDGET AS PER PLAN	Budget (USD)
South Africa	**$106,253,232**

NEXT STEPS

- Finalise workplans with Provinces and Implementing Partners in line with NDoH priorities.
- Meeting between NDoH, Provinces and PEPFAR to ensure alignment before implementation.
- Bi-monthly reviews to monitor progress.

3. A report on an aggregate analysis of healthcare service costs dispensed on undocumented foreign nationals

Undocumented immigrants

- Report on the analysis of:
  - cost for dispensing health services to undocumented immigrants
  - steps to address safety of the patients and staff during the anti-immigrant disruptions in the public health facilities

- Section 27 of the Constitution of the Republic grants **everyone the right** to access health care services
- The Departments of Health **will not turn anyone away** from accessing health care, regardless of their immigration status
- The health departments **do not report separately** on citizens and any category of foreigner
- Undocumented patients are both citizens and foreigners
- There is **no separate cost attributed to foreigners**, legally in the country or otherwise

Safety and security of Patients and Staff

- The Justice, Crime Prevention and Security cluster (JCPS) has met and notes that health and education facilities and services are targeted
- Health departments do not have a mandate to deal with mobs as it is a Public Order Policing (POP) matter
- There is a good working relationship with SAPS will also ensure safety and safety of patients and staff in health care facilities when called, but they cannot protect all health services

Health Patient Registration System (HPRS)

- The Health Patient Registration System (HPRS) issues a unique health identity number that is **verifiable against the population register and other Home Affairs databases**
- Once generated, this number should be used consistently across all facilities to **track patient movement**
- For secure verification, patients must provide identification and ideally biometric data, which requires connectivity to Home Affairs system
- If connectivity is unavailable, patients will still be seen by clinicians, and their data will be uploaded once the system is back online
- The system is designed to generate the HPRN once reconnected as verification cannot occur offline
- The HPRS system feeds the HPRN into patient care systems such as Electronic Medical Record (EMR) and Hospital Management System (HMS2)
- Patient registration and verification begins at admin/reception
- Every facility must eventually be connected to the system
- **Every patient encounter will be visible to the next service provider**

4. Report on the department`s plans to fill key vacancies in senior positions in the healthcare facilities

RECRUITMENT PROGRESS UPDATE

The department has interpreted this as a request for information on:

- Senior nursing management (matrons)
- Senior medical managers (clinical managers)
- Senior clinicians

The data is being extracted from the Persal system and will be presented as a separate table

Departmental Response

- The health departments have been targeting to fill vacancies within the same financial year that the post is vacated. However, due to the financial constraints that have been experienced by the department in recent years, some of the vacancies have taken an average of 3 years to complete

- Recruitment processes are ongoing when funding is available as evidenced by the adverts published through the weekly Public Service Vacancy Circular as distributed by Department of Public Service and Administration

- The department is engaging the Clinical Specialists platforms such as the Colleges of Medicines in South Africa (CSMA) for assistance with recruitment of senior clinical vacancies

5. A detailed update on the department`s tracking and monitoring of its spending reviews

A detailed update on the department`s tracking and monitoring of its spending reviews.

- The Department has established various mechanisms to effectively track and monitor its spending reviews.
- The Department receives monthly and quarterly reports from provinces, which include both financial and non-financial information on expenditure and performance for the respective reporting periods.
- In April 2025, the Department convened a meeting with the Auditor-General of South Africa (AGSA) and all nine provinces under the 10x10 engagement platform to strengthen oversight and accountability on financial management matters.
- Furthermore, a special Chief Financial Officers (CFO) Forum was held virtually with provincial representatives to discuss the additional funding allocation of R20.773 billion for health sector priorities

A detailed update on the department`s tracking and monitoring of its spending reviews.

- The Department also held a meeting with all provincial Comprehensive HIV/AIDS Managers and Finance Managers to deliberate on Section 16 emergency funding, focusing on the allocation, implementation, and monitoring of these funds.
- In addition, the sector convenes two Health Sector Budget and Expenditure Monitoring Review meetings annually, one mid-year and one at year-end attended by all provinces. The half-yearly meeting for the 2025/26 financial year resumed on 24 October 2025 in the Free State Province.
- These engagements collectively ensure continuous monitoring, evaluation, and accountability of expenditure across the health sector.
- Chief Financial Officer has standing item during the Technical National Health Council and National Health Council on Health sector budget and expenditure.

6. Any other matter that will help the Committee to perform its oversight

Update regarding the measures in place to mitigate the accruals and medico-legal claims

A. Accruals trends
B. Impact of the accruals on the current budget for 2025/26FY
C. Measures in place to reduce Accruals
D. Targeted and responsible savings (TARS): Efficiency Gains and Reprioritisation
E. TARS: Review of HR Policies
F. Health Sector Interventions on Accruals
G. Conclusion
H. Medico-legal claims

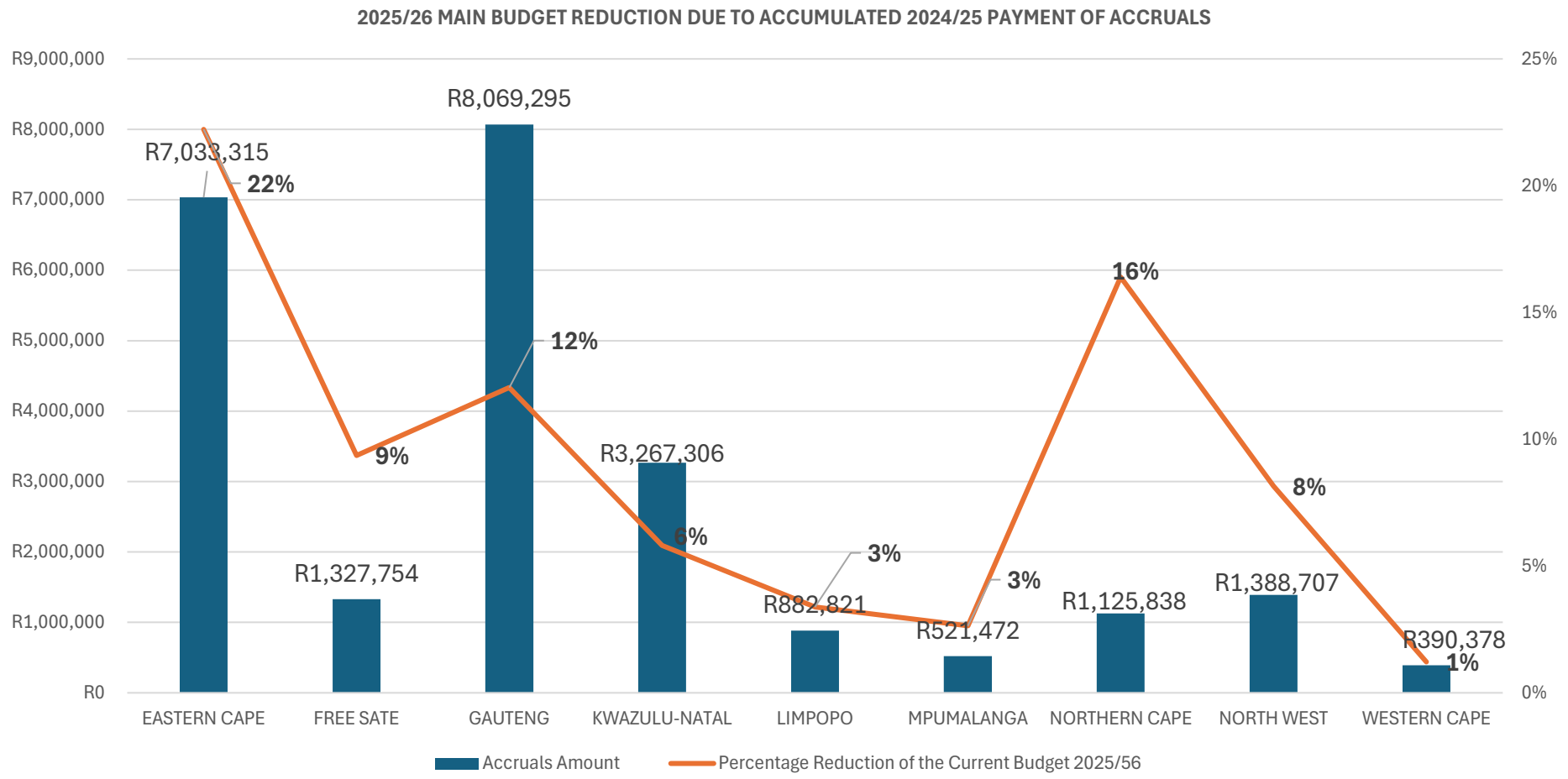
A. Accruals trends for the past five (5) years

R'000	2020/21	2021/22	2022/23	2023/24	2024/25	Year-on-Year % Incr /Decr (2023/24 and 2024/25)	Year-on-Year growth (2023/24 and 2024/25)
Eastern Cape	4 433 170	4 659 982	4 764 773	6 273 891	7 033 315	12,1%	759 424
Free State	662 416	662 416	516 810	1 469 661	1 327 754	-9,7%	(141 907)
Gauteng	6 322 118	6 322 118	6 827 872	6 943 715	8 069 295	16,2%	1 125 580
KwaZulu-Natal	1 783 115	1 485 045	1 838 121	2 803 857	3 267 306	16,5%	463 449
Limpopo	421 606	357 510	767 038	297 317	882 821	196,9%	585 504
Mpumalanga	709 677	449 601	825 870	592 799	521 472	-12,0%	(71 327)
Northern Cape	590 186	1 156 592	908 471	959 856	1 125 838	17,3%	165 982
North West	1 114 976	1 322 914	959 137	1 505 345	1 388 707	-7,7%	(116 638)
Western Cape	508 461	428 911	589 529	652 127	390 378	-40,1%	43 084
Total	**16 545 725**	**16 845 089**	**17 997 621**	**21 498 568**	**24 006 886**	**10,4%**	**2 508 318**

B. Impact of the accruals on the current budget for 2025/26fy (1)

R Thousands	Main Budget	Total Accruals	Main 2024/25 less Accruals	
Provinces	2025/26	2024/25	Actual Main for the year	% 2025/26 Budget Reduction due to Accruals
EASTERN CAPE	31 652 682	7 033 315	24 619 367	22,2%
FREE SATE	14 187 504	1 327 754	12 859 750	9,4%
GAUTENG	67 042 497	8 069 295	58 973 202	12,0%
KWAZULU-NATAL	56 211 801	3 267 306	52 944 495	5,8%
LIMPOPO	26 073 702	882 821	25 190 881	3,4%
MPUMALANGA	19 750 975	521 472	19 229 503	2,6%
NORTHERN CAPE	6 868 747	1 125 838	5 742 909	16,4%
NORTH WEST	17 040 332	1 388 707	15 651 625	8,1%
WESTERN CAPE	32 007 601	390 378	31 617 223	1,2%
Total	270 835 841	24 006 886	246 828 955	8,9%

Budget reductions due to 2024/25 accumulated accruals (3)



C. Measures in place to reduce year-on-year increase of accruals

- The Health Sector in collaboration with National Treasury implemented the Approved Accrual Strategy over the years to ensure the reduction of Accruals Year-on Year

- National Treasury through various forums (i.e. Health Functional Groups, 10X10 etc.) introduced **'Targeted and Responsible Savings' (TARS)** for the 2025/26 FY
  - ✓ TARS is a new budget mechanism, whereby departments are required to identify low-priority or underperforming programmes in order to reduce aggregate expenditure and/or reallocate funding towards priority areas
  - ✓ The programmes were identified for the TARS list using multiple criteria, including performance, previous spending review findings, and presented during the meeting between National Treasury and Health Sector as per the decision of the Health Functional Group meeting held on 21 August 2025
  - ✓ TARS programmes will undergo spending reviews on areas previously identified in spending reviews (e.g. laundry, security, catering, etc.) for efficiency gains with the advantage to reduce accruals

D. TARS efficiency gains and budget reprioritisation (1)

Amongst others, in realization of TARS implementation the following will be the focus areas:

- **Property Payments**: Manage and review contracts (security, waste, cleaning etc.) and management of municipal accounts (meter reading verifications, water leaks identification, billing etc.)
- **Lab Services**: Implementation of electronic lab services gate keeping
- **Legal Services**: Reduction of the outflow of funds for legal settlements, legal fees and the interest accruing therein needs to be achieved with stringent adherence to the Case Management / Process Flow methodology for Clinical Medicolegal Matters (Legal Defence)
- **Outsourced services**: Limitation of agency support and outsourced services on administration

TARS efficiency gains and budget reprioritisation (2)

Amongst others, in realization of TARS implementation the following will be the focus areas:

- **Operating leases**: review of staff residential accommodation expenditure, consumptive analyses variance to annual demand forecasting and the alignment of qualifying officials in terms of policy prescripts and to compensatory allowances provided as part of remuneration packages.
- **Inventory**: Fuel, oil and gas: Saving realisation on uninterrupted power supply or stability due to loadshedding.
- **Blood and Blood Products**: Instituting gold standard practices (cross-matching) and returning of blood products on time when not utilized to avoid wastages.
- Continuous implementation of NT **austerity measures**.
- **Reprioritisation of services** to yield savings to curb the burden exacerbated by year-on-year increase of accruals

E. Review of HR policies for efficiency gains

Implementation, monitoring and evaluation of HR Policies

- To review HR Policies on commuted overtime(COT), Community Service (CS), Intern remuneration, Rural Allowance, Remunerative Work Outside of the Public Service (RWOPS)
- Management of commuted overtime
- Review of Health Sector Organogram
- Review of Occupational Specific Dispensation (OSD)

F. Health sector interventions on accruals

National Health Council (NHC)

a statutory MINMEC in terms of section 22 of the National Health Act, 2003 (Act No. 61 of 2003)

decided on **four national priorities** for the current MTEF

1. Doctors (Group 2 COT) 1200; Nurses 200; Other HCPs 250 (wef 01 Oct 2025)
2. Implement Community Health Workers (CHWs) with matric at L2N1 (carry-through cost plus 4,5%)
3. Fixed and Committed procurement of 1,4m items (beds, matrasses and linen) (R1,35bn of which R273 million for linen from SEE factories for persons with disabilities)
4. Balance for critical accruals (NHLS, SAMED, oxygen, medicines and blood products)

Modelled distribution and targets based on PES allocations but awaiting final figures from NT

DESCRIPTION OPTION C	FINANCIAL IMPLICATION
Employment of Health Professional	R890 298 996
Implementing Court order on Community Health Workers	R716 788 899
Procurement of hospital beds, linen and matrasses	R1 346 174 606
Reduction of accruals within health sector	R3 752 737 500
Total amount	**R6 706 000 000**

Available for accruals in 2025/26

2026/27 – R3,6bn
2027/28 – R3,7bn
But not equitably allocated to provinces because of formula

Health sector interventions on accruals – Payment priorities

PRIORITY 4 - KEY ACCOUNTS DEBT ACCRUED

PROVINCE	AFROX	AFROX PAYMENT	SAMED	SAMED PAYMENT	NHLS	NHLS PAYMENT	SANBS	SANBS PAYMENT	MEDICINE	MEDICINE PAYMENT	TOTAL ACCRUAL (EXC AFROX)	ACCRUAL PAYABLE (INCL AFROX)
	Owing in MAR 2025	85%	Owing in MAR 2025	30%	Owing in MAR 2025	30%	Owing in MAR 2025	30%	Owing in MAR 2025	30%		
EC	89 898 772	76 413 956	138 988 553	41 696 566	1 333 611 242	400 083 373	338 718 285	101 615 485	600 599 523	180 179 857	2 411 917 603	**799 989 237**
FS	27 629 686	23 485 233	117 264 678	35 179 403	523 429 619	157 028 886	102 375 147	30 712 544	542 450 293	162 735 088	1 285 519 737	**409 141 154**
GP	65 631 200	55 786 520	602 587 454	180 776 236	1 902 348 275	570 704 482	311 385 123	93 415 537	72 395 448	21 718 634	2 888 716 300	**922 401 410**
KZN	36 813 933	31 291 843	187 360 470	56 208 141	1 902 708 605	570 812 581	185 654 104	55 696 231	62 374 972	18 712 492	2 338 098 150	**732 721 288**
LP	21 449 492	18 232 068	48 203 551	14 461 065	58 525 531	17 557 659	453 337	136 001	103 902 762	31 170 829	211 085 181	**81 557 623**
MP	14 161 017	12 036 864	45 952 256	13 785 677	59 539 443	17 861 833	14 872 782	4 461 834	364 480 379	109 344 114	484 844 859	**157 490 322**
NC	26 587 160	22 599 086	122 689 380	36 806 814	402 898 248	120 869 475	45 315 325	13 594 597	254 798 306	76 439 492	825 701 259	**270 309 464**
NW	63 688 828	54 135 504	24 220 741	7 266 222	475 036 214	142 510 864	96 124 197	28 837 259	213 889 099	64 166 730	809 270 251	**296 916 579**
WC	10 869 269	9 238 879	111 091 421	33 327 426	29 852 021	8 955 606	134 964	40 489	77 649 981	23 294 994	218 728 386	**74 857 395**
TOTAL	**356 729 357**	**303 219 953**	**1 398 358 504**	**419 507 551**	**6 687 949 197**	**2 006 384 759**	**1 095 033 264**	**328 509 979**	**2 292 540 763**	**687 762 229**	**11 473 881 727**	**3 745 384 472**

Percentages to be paid in 2025/26

G. Conclusion

- Budget is still **below pre-pandemic spending levels in real terms**
- **There has been severe austerity for a decade, which has undermined public health**
- Health has been allocated an **additional R6,7bn in 2025/26 FY** (R20,77bn over MTEF)
  - NT communicated with provincial treasuries the allocation
  - All allocated to provincial PES
  - In-year allocation according to COE and not PES formula
- NT requires departments to focus on efficiency, savings, and equitable distribution of available funding and reduction of accruals
  - The TARS list is one of the key new budget instruments to **"free up fiscal space"**
  - This means reducing services
- NHC agreed to pay off accruals as **one of four national priorities** for the additional funds
- **Without consideration of paying off accruals provinces like E Cape, Gauteng and KwaZulu Natal will NEVER stabilize**
  - their suppliers punish them, they can't fill posts or pay overtime, their conditions deteriorate and so they have more medicolegal issues and spend money paying out instead of patient care
  - this vicious cycle must be broken. Rather provinces need to be set targets as rewards for accruals being paid off

THANK YOU

ngiyathokoza!

ro livhuwa!

dankie!

ke a leboga!

enkosi!

thank you!

ndo livhuwa!

inkomu!

ke a leboha!

ngiyabonga!

siyabonga!