Foreword

This is the fifth South African Health Review published by the Health Systems Trust.

Policy makers, planners and managers in the health sector remain our primary target and over the years, readership has expanded to include researchers, academics, and students, as well as health and development organisations and health systems experts in South Africa and internationally.

This broad readership offers a challenge to planners and writers of the Review, which aims at providing a comprehensive and detailed account of developments in the South African health system over the last twelve months.

The chapters represent a combination of commissioned research, experience, and available published literature, and the focus on equity, central to the 1998 Review, has been retained in a number of chapters. Progress to achieving equity is especially highlighted in the chapters on the distribution of financial and human resources. Recognising that the greatest inequity exists in the maldistribution of resources between the public and the private sectors, this Review pays great attention to the role of the private sector, and also to the evolving partnerships between these two sectors.

The Board of Trustees of the Health Systems Trust is proud to be associated with this publication. We recognise the dedication and hard work of a large number of people who have contributed to its production, and thank all the contributing researchers, writers and reviewers as well as the staff of the Health Systems Trust. We trust that the Review will continue to support the transformation of the health sector, and in so doing, play a part in the improvement of health care in South Africa.

Professor Marian Jacobs
Chairperson
Board of Trustees

I am a Healthy Child.

c d e f g h
5 6 7 8 9 10
1
+2
=3

Contents

	Overview	***xii***
1	***Poverty, human rights and health*** Irwin Friedman	***1***
2	***Health Legislation*** Stephen Harrison	***13***
3	***Equity in public sector health care financing and expenditure*** Di McIntyre, Stephen Thomas, Sandi Mbatsha, Luvuyo Baba	***27***
4	***Managed health care*** Alan Rothberg, Reg Magennis, Susan Mynhart	***53***
5	***Health insurance dynamics*** Neil Söderlund	***61***
6	***The public-private mix*** Jane Goudge	***69***
7	***STD care in the private sector*** Helen Schneider, Duane Blaauw, Bongani Magongo, Ipeleng Khumalo	***83***
8	***Patient choice of primary care provider*** Natasha Palmer	***95***
9	***State-aided Hospitals*** Mary Kawonga, Stephen Knight	***103***
10	***Health Services provided by religious communities*** Barbara Schmid, Prof. JR Cochrane, Prof. CA Wanamaker, Hajira Khalfe, Lyn Holness	***121***
11	***Establishing the District Health System*** David McCoy, Beth Engelbrecht	***131***
12	***District health information systems*** Jeff Muschel	***147***

13	***Drug policy*** Andy Gray, Fatima Suleman	161
14	***Improving quality of services*** Gary Morris	175
15	***The production of doctors*** Uta Lehmann, David Sanders	187
16	***Distribution of human resources*** Dingie van Rensburg, Nicolaas van Rensburg	201
17	***Monitoring the implementation of community service*** Steven Reid, Daphney Conco	233
18	***Traditional Healers*** Engela Pretorius	249
19	***Occupational health services in South Africa*** Mohamed Jeebhay, Belinda Jacobs	257
20	***Environmental health services*** Angela Mathee, Frikkie Swanepoel, Andre Swart	277
21	***Health promotion*** Nancy Coulson	289
22	***HIV/AIDS and STDs*** Gary Adler, Obed Qulo	301
23	***Tuberculosis*** Lesley Bamford	315
24	***Trauma and injury*** Margie Peden, Alex Butchart	331
25	***Mental Health*** Alan Flisher, Wasima Fisher, Hasina Subedar	345
26	***Termination of Pregnancy*** Sanjani Jane Varkey, Sharon Fonn	357
27	***Health Research in South Africa*** Anthony Mbewu, Khosi Mngomezulu	369
	Appendix	385
	References	387
	Health and related indicators	399
	Glossary	409
	Index	415

Acknowledgements

Editors

Nicholas Crisp and Antoinette Ntuli

Assistant Editors

Elizabeth Clarke and Candy Day

Research Commissioned by

Gcinile Buthelezi, Jane Edwards-Miller, Nonhlanhla Makhanya, Fatima Suleman

External Reviewers

National and Provincial Departments of Health
Joce Kane-Berman, Department of Environment and Cultural Affairs, Western Cape
Leslie London, Department of Community Health, University of Cape Town
Francie Lund, Centre for Social and Development Studies, University of Natal

Internal Reviewers

Peter Barron
David Coetzee
Nonhlanhla Makhanya
David McCoy

Cover

Cover drawing by Mantoko Mofokeng, a grade 4 pupil from Bethlehem in the Free State. Winner of the "Healthy Child" Competition organised by NPPHCN and the Nelson Mandela Children's Fund and funded by the Henry J Kaiser Family Foundation.

Other Support

We wish to thank the many people as well as the staff of the Health Systems Trust who participated in putting this Review together. Khatatso Mokoetle of NPPHCN for helping arrange for us to use the cover photo. Andy Gray, David Mametja and Mosula Ntshona who helped develop and conceptualise the framework for the contents. Lynda Campbell, Shonagh Matti and the staff of The Press Gang for their commitment and dedication to ensuring that the design, layout and printing are of such a high standard. Debbie Bradshaw and Nolwazi Mbananga of the MRC and Kefiloe Mokati of the Department of Health for revising and updating the tables of indicators at the end of the Review. All the Reviewers who took time in their busy schedules to read and comment on chapters. The individual authors and all the researchers who assisted with the data collection for the chapters. We thank you all for your help and support.

I am a Healthy Child.

c d e f g h
5 6 7 8 9 10

Overview

As we draw to the end of the century, significant strides have been made in developing a unified public health sector that is district based and underpinned by the principles of the primary health care approach. An explicit commitment to equity underlies the transformation process. However transformation, and the achievement of equity, are hampered by a variety of factors including difficulty in redistributing resources and a shrinking public sector budget. The poor relationship between the public and private sectors, and the contribution of the private sector to the inequity in health care in the country are cause for serious concern. In addition the impact of HIV/AIDS upon the health system is beginning to be felt with some hospitals estimating that up to 35% of beds are occupied by people with HIV related infections. The National Health Bill, expected to replace the 1977 Health Act, and to provide the broad enabling legal framework for current policies, is still awaited. This overview highlights some of the most important findings of the 1999 South African Health Review.

Health Status

South Africa's first Demographic and Health Survey indicates that infant mortality and maternal mortality rates are alarmingly high, with wide provincial variation. The rate of infant mortality in the Eastern Cape is 61.2, almost twice as high as in the Western Cape, where the rate is 30.2. There is also wide variation in levels of immunisation which are very poor in some provinces. In the Eastern Cape and KwaZulu-Natal rates are around 50% and only the Northern Cape has achieved 80% immunisation coverage. These figures show that for some parts of the country the standard of health care is lower than it is in many other poorer sub-Saharan countries.

Authors

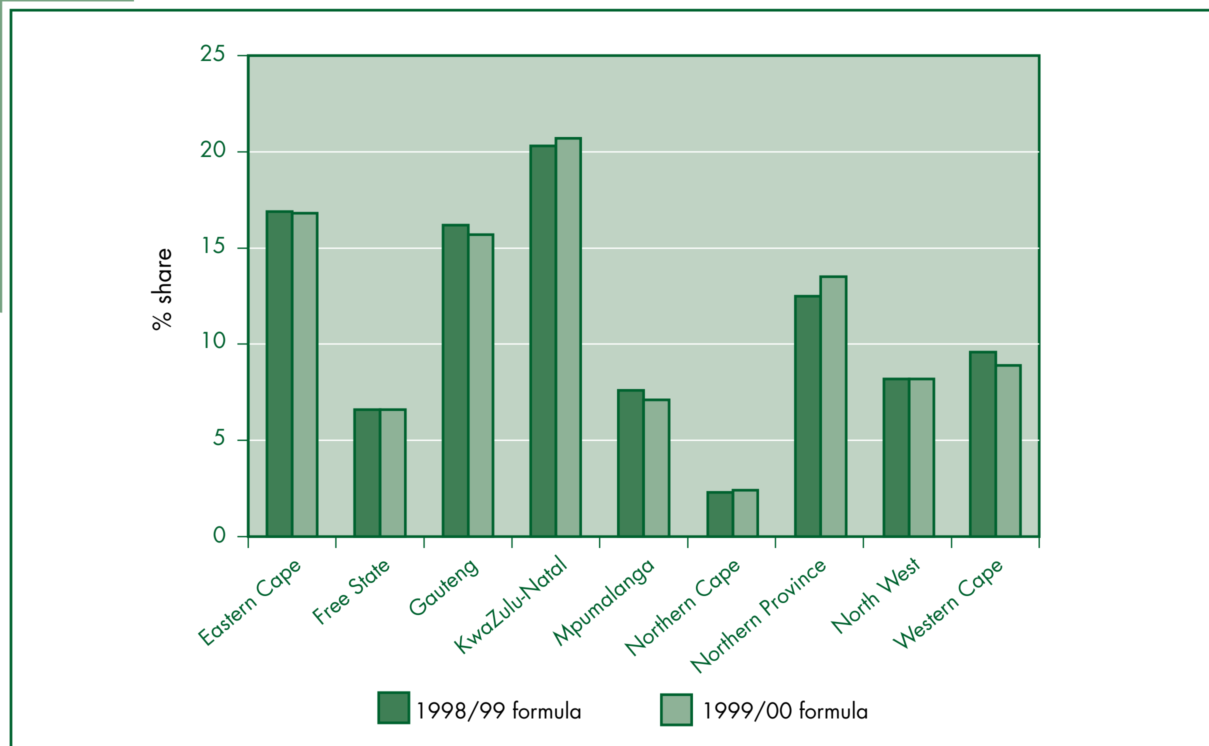
Nicholas Crisp

Antoinette Ntuli

Public Sector Health Care Financing

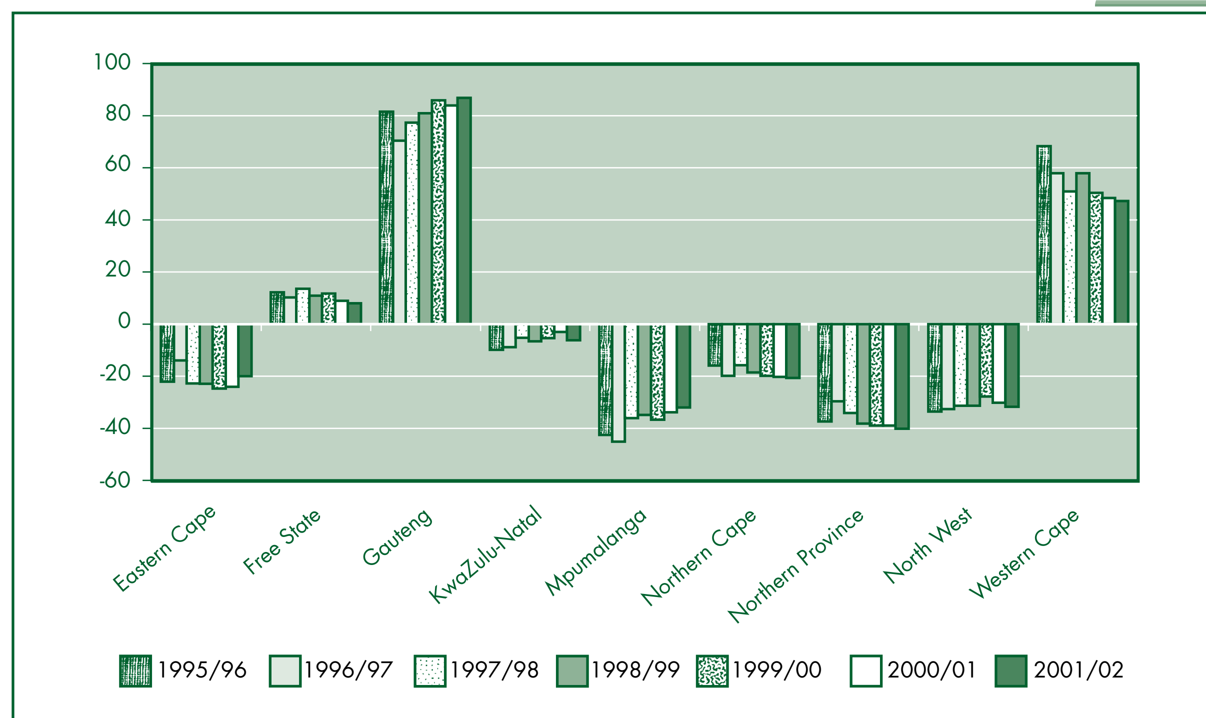
In the public sector, changes in the Department of Finance formula for allocating money to provinces have resulted in some of the "better off" provinces experiencing a reduction in their share, while the share of some of the "historically poorer" provinces has increased. However, the changes in the formula, despite containing a "backlogs" component (3%), cannot be said to be completely equity promoting since at least two of the historically disadvantaged provinces, Eastern Cape and Mpumalanga, face a decline in their share.

Figure 1: Changes in provincial budget share targets with new formula



An update on inter-provincial spending on health indicates that the trends highlighted in 1998 continue and that the introduction of fiscal federalism in 1997 has reversed or slowed the achievement of equity. Per capita expenditure in Gauteng, the Northern Cape, Northern Province and North West is moving away from the national average.

Figure 2: Percentage difference between real per capita total provincial health expenditure/ budgets and national average



Case studies analysing intra-provincial resource allocation in two provinces, reported in the 1998 Health Review, found that the districts with the greatest budgets had four times as much money to spend as those with the least. In contrast with inter-provincial expenditure, an update on expenditure in these provinces demonstrates a move towards equity. Inter-district allocations in both provinces are moving closer to the provincial average than they were in 1998.

Public-Private Relationships

The Medical Schemes Act, by outlawing "risk-rating", should reduce the number of seriously ill patients having to leave the private sector because they cannot afford higher premiums imposed by medical schemes. At a primary level many low-income groups are paying for private sector care, reinforcing the inequity between the public and private sectors.

While much attention has been focused on the financing aspects of the private sector, more work needs to be done on how the quality of care in the private sector can be monitored. There is plenty of evidence to suggest that some care in the private sector is of poor quality and influenced by commercial considerations. For example, as many as 63% of all visits for STDs are to private doctors and yet at most 30% of doctors are giving effective treatment for STDs. If this country is to accept a large commercial health sector an important challenge will be to imbue the sector with a greater sense of ethics, integrity, patient loyalty and a culture of caring.

Table 1: Reported treatment of STD syndromes by GPs (n=120)

	Urethral discharge	Genital ulcer	PID*
Percentage reporting effective treatment	28.3%	15.5%	4.4%

*PID: pelvic inflammatory disease

Strategies to improve the quality of care in the private sector may also require state intervention of a regulatory nature. However the introduction of these measures necessitates there being the human resource capacity available to monitor regulations. The idea that a free service is an inferior service needs to be challenged, as does the idea that the private sector is inherently superior to the public sector. One strategy for this is patient education. If the South African public were more health literate they would be in a better position to make choices about if and when to seek private care.

District Health Systems Development

A major stumbling block to the implementation of the District Health System has been the interim nature of local government structures. While progress has been made in identifying larger municipalities, the boundaries of local municipalities have yet to be finalised. It is likely that many health district boundaries will need to be adjusted to accommodate the changes in local government demarcations. The devolution and transfer of district health services to local government will now become a major preoccupation of all provinces, and will require a careful, slow and incremental approach if the quality of services is not to deteriorate as has been the experience of other countries.

A confusion of roles between the national and provincial departments of health and the district level persists. Effective implementation of the district health system needs managers at district level to have control over resources and decision-making. This implies putting decentralised decision making into practice and for staff at national and provincial level to redefine their roles to provide strategic and policy level support.

It is clear that we need to move quickly away from an emphasis on structure to an emphasis on the delivery of services. Concentrating on providing excellent services in priority programmes will not only help improve health but help shape the structure of the health system into a more effective and efficient form.

Central to effective decision making for districts is access to accurate and appropriate information. Much attention has been given to the development of standardised data collection tools. There has been less progress with the standardisation of the content and quality of data collected. The regular and effective use of routine data for the purpose of strengthening management and informing decision remains a challenge to the country.

The introduction of the essential drugs list appears to have facilitated rational drug use and the availability of key items has improved over time. However appropriate and rational drug prescribing remains a challenge. Of serious concern is the shortage of pharmacists in the public sector, especially in district hospitals.

Table 2: Pharmacist vacancy rates

Province	Number of state hospitals without a pharmacist	% vacant public sector pharmacist posts
Eastern Cape	11	20
Free State	11	36
Gauteng	0	39
KwaZulu-Natal	4	14
Mpumalanga	3	7
Northern Cape	13	19
Northern Province	15	45
North West	7	43
Western Cape	3	12

The introduction of community service for pharmacists may go some way to addressing shortages. However so far the priority has been to provide adequate numbers of pharmacy support personnel, and progress in this area has been slow.

Human Resources

Transformation of the health system implies reform of the curricula for training health professionals. Although some progress has been made, there are still very many problems and challenges to be overcome to ensure that South African health workers are equipped to provide the sort of health care required to improve the health status of the country.

A key strategy to "distribute health personnel throughout the country in a more equitable manner" has been the introduction of community service for doctors. Assessment of the first year of community service indicates that this aim has been partially met. Less than 25% of community service doctors are placed in rural hospitals which qualify for the rural allowance, while 55% are working in regional, tertiary and specialised hospitals. The challenge of getting doctors to the periphery is a huge logistical one.

Table 3: Distribution of community service doctors by facility in 1999

Site of allocation	Number of CS doctors	Percentage
Community health centres	22	45
District hospitals	479	
Regional hospitals	401	55
Tertiary & specialised hospitals	186	
SA Military Health Services	34	
Total	1122	100

It does appear that community service has been successful overall in contributing to improved provision of health services and many doctors doing community service valued the opportunity to feel that they were "making a difference". Greater attention needs to be given to developing criteria for facilities where community service doctors are allocated, to developing the supporting infrastructure (such as residential accommodation) and to ensuring that doctors are involved in areas of greatest need within a district. Addressing these factors will help the community service programme to meet its stated aims.

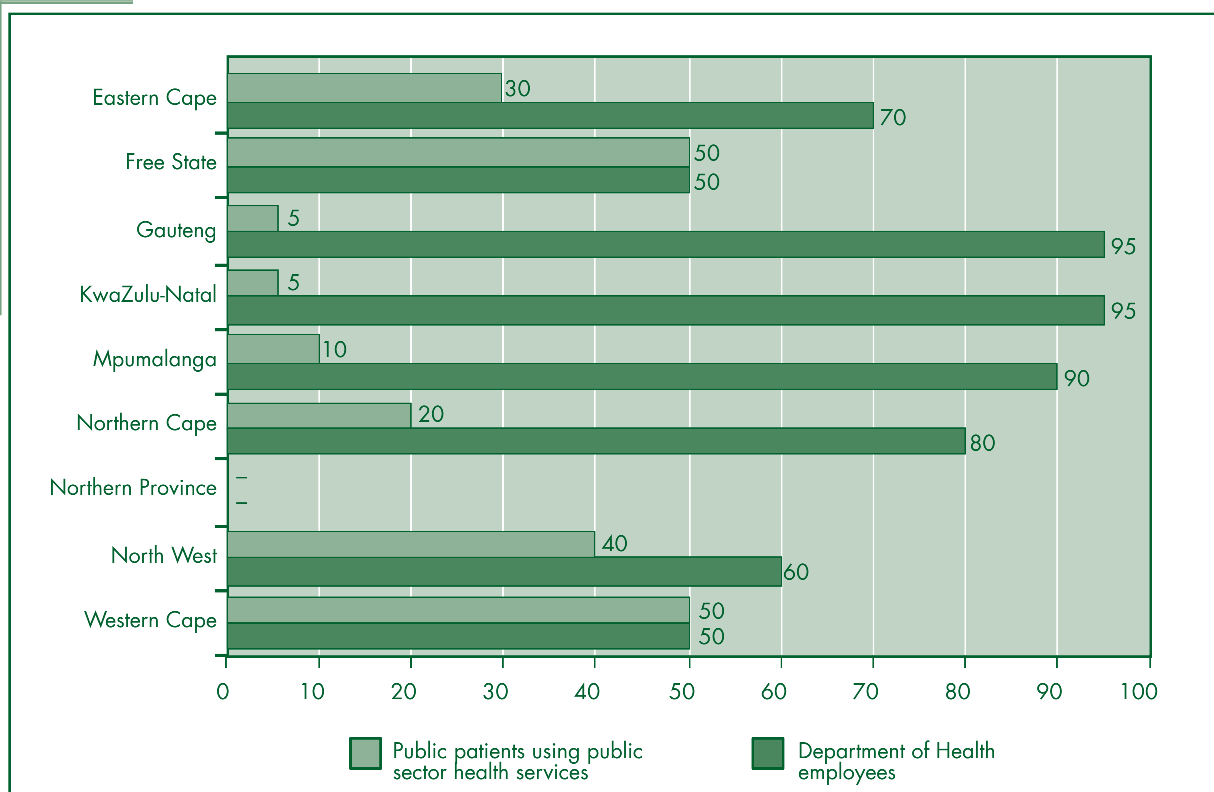
Excellent progress has been achieved in addressing racial imbalances in the staffing of the public health sector. The implementation of affirmative action policies over the last five years means that women are now better represented in public sector management. However in some provinces women are still under-represented in middle, senior and top management positions. Staff morale and productivity are poor and are contributing to people not accessing services or resorting to care in the private sector.

There has been some progress towards the registration of traditional healers and their incorporation into the health system, however there is still a long way to go.

Health Care Support Services

Transformation is underway, albeit at different paces in the three health care support services of occupational health, environmental health and health promotion. From an equity perspective it is of concern that while the main function of occupational health services in the public sector is to provide services to under-served groups in the community, in practice services are primarily providing for DoH employees.

Figure 3: Proportion of Provincial Occupational Health Sub-Directorate's time (%) devoted to occupational health service development in the various provinces of South Africa



Note: No information was provided by the Northern Province

South Africa faces serious environmental health challenges. There is a need to build consensus that the role of the environmental health officer is to focus on basic development needs, and to build capacity for environmental health services. Inequity in the distribution of environmental health officers mirrors patterns of inequitable distribution of other health workers. Some of the lowest levels of coverage of EHOs are in provinces with some of the most pressing environmental health challenges such as the Eastern Cape and the North West.

Table 4: Distribution of Environmental Health Officers

Province	Area (km²)	EHO: population ratio	Shortfall
Eastern Cape	169 600	1:25 951	185
Free State	129 480	1:25 956	120
Gauteng	18 810	1:16 187	244
KwaZulu-Natal	92 180	1:23 249	437
Mpumalanga	78 180	1:19 036	126
Northern Cape	384 987	1:12 433	15
Northern Province	123 280	1:23 455	237
North West	116 190	1:26 007	190
Western Cape	123 390	1:11 282	47
South Africa	1 242 287	1:18 948	1804

Although South Africa has some very vibrant health promotion activity, health promotion services in provinces are generally weak. Health promotion should play a role in re-orienting health care and ensuring that health promoting activities, essential to the primary health care approach, are not squeezed out by the demands of treatment and care. Strong promotion of health could play an important part in facilitating community participation and community education on health matters as well as empowering health care consumers, and enabling them to be more discerning, both about when to seek care as well as what type of care to choose.

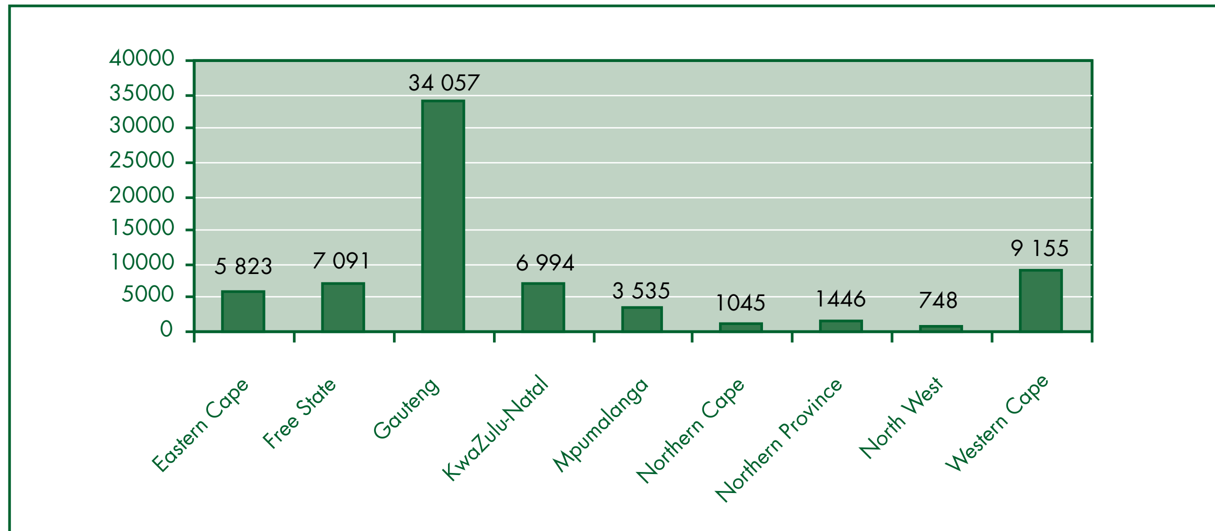
Priority Programmes

There has been progress in the implementation of the national TB control programme and a number of demonstration and training sites have shown that district TB programmes can achieve cure rates of more than 80%. The close link between HIV and TB necessitates that HIV/AIDS and TB programmes are co-ordinated and work together.

The catastrophically high levels of HIV infection, especially in teenage women, demand an urgent need for the translation of political commitment into strong national and provincial HIV/AIDS programmes. Gauteng stands out among the provinces as an example of where strong programmes are developing.

The Choice on Termination of Pregnancy Act has resulted in a steady increase in the number of terminations of pregnancy (TOPs) since February 1997. Unfortunately a number of barriers prevent women accessing TOPs. Important barriers include negative attitudes of staff and the poor availability of abortion services. There is wide variation in the number of TOPs performed across the provinces, with 45% of all TOPs done in Gauteng, and only 1% in the North West Province.

Figure 4: Number of TOPs per province February 1997 – January 1999



Conclusion

South Africa's commitment to a unified health system underpinned by principles of equity bodes well for the provision of health care. This Review recounts many success stories in moving towards the achievement of this vision. It also attempts to highlight some of the stumbling blocks on the path to the future.