Gail Andrews[i]

Yogan Pillay[ii]

Authors

1 strategic

Abstract

This chapter attempts to answer the following questions: what progress has been made with respect to achieving the ten priorities of the 2004-2009 strategic framework of the Department of Health? What are some of the major constraints on implementation thereof? Within the stated list of priorities, which priorities should drive the agenda of the health sector in order to achieve the Millennium Development Goals and the President's vision for a developmental state? President Mbeki's emphasis on the capacity of the state is in keeping with the characterisation of the developmental state in the literature – that is, a developmental state needs a bureaucracy that can deliver. This chapter reviews the strategic priorities of the National Health System using this lens.

We conclude the chapter with the following recommendations: firstly, health personnel need to take seriously the challenge of building a strong, efficient and effective health system, and commit themselves to acting in ways that will push forward the agenda of the leadership. This in turn will require that political leaders as well as managers in the health system are able to clearly articulate and communicate a vision and a mission that resonates with front line health workers, and that the vision is translated into clear operational strategies. Secondly, the operational strategies need to be developed with and should capture the imagination of those charged with its implementation. The third crucial ingredient required for building a developmental state is an effective governance and management system. The fourth necessary ingredient is a critical mass of skilled and motivated health managers and health workers at all levels of the health system. Thus, urgent steps need to be taken to produce and implement a strengthened national human resources plan for the health system - within the framework of a comprehensive primary health care approach - since this is central to building the state's capacity and hence a developmental state. Also, given the centrality of PHC services to the health system, the possibility of ring fencing PHC funding in each province should be urgently considered.

i SAHARA Human Sciences Research Council

ii National Department of Health

priorities for the **national health system** (2004-2009)

contributions towards building a model developmental state in South Africa

Introduction

The chapter will assess the contribution of the strategic priorities selected by the Health MinMEC (now called the National Health Council) in April 2004 to secure the mission of the South African government of building a developmental state. The chapter focuses on the priorities themselves, as well as the roles of the different spheres of government and the capacity of the state.

The role of the state has recently become an issue for debate. For example, in its State of the Nation Report, 2004-2005, the Human Sciences Research Council (HSRC) notes that:

> *"...whether or not the Mbeki government is on the way to refashioning itself into a developmental state, it is going to encounter three sets of problems in its bid to boost growth and development in South Africa. These relate to first, state capacity; second, the global and African environment; and third, democratic accountability."*[1]

The issue of the capacity of the state was discussed at the Cabinet lekgotla in January 2005[2] and again in the President's State of the Nation address in February 2005,[3] where the President announced that the Forum of South African Directors-General (FOSAD) had been charged with the responsibility of reviewing and reporting on this issue by March 2005. The capacity of the state was recently discussed by a special extended Cabinet session, at which Premiers, Deputy Ministers and Directors-General were also part of the discussion of the report of FOSAD.[4] It appears that the FOSAD's mandate was extended at this meeting to include other issues: "...to (ensure) that government across all the spheres improves its capacity to lead society in taking the country to a higher growth and development trajectory and in providing services to citizens more effectively and efficiently."

If the mission of this government is the building of a developmental state, we need to understand what such a state is and what other options exist. The next section will try to uncover both issues briefly.

Building the developmental state to enhance service delivery

In the 'ANC Today' of February 2003, the issue of a building of developmental state was raised as a key objective for South Africa (SA). In an article entitled "A developmental state leading the fight against poverty" the 'ANC Today' cites the President's State of the Nation address at length with respect to the task of development and fighting poverty, so as to achieve a better life for all.

More recently the President, in his budget speech to Parliament, also referred to the need for a developmental state:

> *"Our experience over the last eleven years .... suggests that we have to attend to a number of issues that are critical to the strengthening of the developmental state we have been striving to build. As in all other countries, we must proceed from the fact that the state is the largest social institution in any country. We must therefore expect that its capital, human resource, managerial, technological and organisational requirements will reflect the society from which it originates."*[5]

So what is a developmental state and what are the other options?

In the HSRC's State of the Nation report,[1] reference is made to the studies of third world states by Evans, who suggests that states may be predatory, intermediate and developmental. Predatory states are:

> *"...controlled by a small political elite and often an authoritarian leader, is characterised by an incoherent and inefficient administration....the developmental state is characterised by a coherent bureaucracy with an homogenous administrative culture which has the capacity to perform the functions assigned to it...this bureaucracy has a considerable degree of autonomy vis-à-vis both political and economic elites....intermediate states are located between the two extremes. They possess considerable administrative capacity."*[a]

This chapter accepts the need for a developmental state and focuses on the extent to which the strategic priorities of the health system support this. The characterisation of the developmental state therefore provides the rationale for the emphasis by the President on the capacity of the state. Simply put, a developmental state needs a bureaucracy that can deliver. Such a bureaucracy must therefore have the necessary authority, structure and expertise to function effectively.

The remainder of the chapter will review the ten point plan health priorities of the national Department of Health (DoH) in this light.

Health sector strategic framework, 2004 - 2009

In 1999, the Minister of Health and the MECs for Health adopted the health sector Strategic Framework, 1999-2004, which reflected the top 10 priorities for the health sector for this period.[6] In 2004, a new set of priorities were identified. The strategic priorities for 2004-2009[7] evolved out of an assessment by the DoH of the work it had set itself for the period 1999-2004, as well as an overall assessment of its achievements of the past 10 years, its regional and international obligations, and work that remains to strengthen the national health system in SA.

a Evans P (1995) Embedded Autonomy: States and industrial transformations. Princeton: Princeton University Press. In [ref 1] Daniel J, Southhall R and Lutchman J. (p.xxxii). Introduction: President Mbeki's second term: Opening the Golden Door? (pp. xix-xl) In Daniel J, Southhall R and Lutchman J (eds) State of the Nation, 2004-2005. HSRC Press: Pretoria; 2005.

The new strategic framework was informed by an analysis of reports from managers in the DoH and from individual provincial reports. As the Framework[7] aptly states, these priorities build on the policies and achievements of the past decade, which are outlined in such documents as the ANC Health Plan,[8] the RDP[9] the White Paper for the Transformation of the Health System,[10] the annual reports of the provincial departments of health and that of the national DoH.

The key focus of this new framework, (2004-2009) is captured in the mission of the national DoH, which is:

> *"to improve health status through prevention of illness and the promotion of healthy lifestyles and to consistently improve the health care delivery system by focusing on access, equity, efficiency, quality and sustainability."*

Compared with the 1999-2004 Strategic Framework, there is a much stronger focus in the new framework on the promotion of good governance and healthy lifestyles. The focus in the new framework on promoting good governance includes the building of strong institutions to successfully achieve the goals of a developmental state, and is aptly placed at the top of the list of priorities. The ten priorities of the 2004-2009 framework are:

- Improve governance and management of the National Health System (NHS).
- Promote healthy lifestyles.
- Contribute towards human dignity by improving quality of care.
- Improve management of communicable diseases and noncommunicable illnesses.
- Strengthen primary health care, Emergency Medical Services (EMS) and hospital service delivery systems.
- Strengthen support services.
- Human resource planning, development and management.
- Planning, budgeting and monitoring and evaluation.
- Prepare and implement legislation.
- Strengthen international relations.

Having articulated its strategic priorities, the task that remains for the DoH is the implementation thereof. To this end, this chapter attempts to answer the following questions:

What progress has been made with respect to the above priority areas?

What are some of the major constraints on implementation thereof?

Within the stated list of priorities, which priorities should drive the agenda of the health sector in order to achieve the Millennium Development Goals (MDGs) and the President's vision for a developmental state?

Achievements and challenges

This section reviews the early progress made and remaining challenges against the priorities of the Health Sector Strategic Framework, 2004-2009.

Improve governance and management of the National Health System

The White Paper on the Transformation of the Health System for South Africa[10] clearly states that the aim of the transformation is to create a unified NHS. In addition, the recently proclaimed National Health Act, No. 61 of 2003,[11] (Health Act), provides for the creation of a NHS. However, it is only by locating the creation of a NHS within the provisions of the Constitution that one can appreciate what this means. The Constitution provides for three distinct but interdependent spheres of government. This implies that provinces and municipalities have a certain degree of autonomy.

The Health Act provides a legal framework for the strengthening of the governance and management structures of the NHS within the provisions of the Constitution. On 6 May, 2005 the Minister of Health, in terms of the Health Act, constituted and held the first meeting of the National Health Council (NHC) (which replaces the Health MinMEC). Provinces must establish Provincial Health Councils within 90 days of the proclamation of the Health Act i.e. by the end of July 2005. In addition the MECs for health are expected to establish district health councils. These issues were raised by the Minister of Health in her budget speech to the National Council of Provinces (NCOP) on 1 June 2005.

Experiences over the past 11 years suggest that there is a need to strengthen cooperative governance and to have a better understanding of how national policies are translated into practice at provincial, district and institutional levels. This is particularly important in the context of fiscal decentralisation, in which the provinces determine the budget of the provincial health departments. These issues have been discussed in previous SA Health Reviews.

A second issue with respect to governance is the extent to which the implementation of the Health Act will expand community participation in the governance of the health system at all levels. While most hospitals and many clinics have hospital boards and clinic committees, many of these are not effective as they enjoy no real powers. Good governance also requires the strengthening of human resources management systems and the necessary infrastructure needed to run an efficient bureaucracy. This is explored further in the section on human resource planning, development and management.

Promote healthy lifestyles

One of the biggest achievements, for which the Minister of Health received an award on behalf of SA, in the area of health promotion has been the introduction of legislation on tobacco control aimed at reducing morbidity related to smoking. Surveys suggest that legislation and policies implemented to curb tobacco use amongst both youth and adults have resulted in a decrease in smoking prevalence between 1998/99 and 2002.[7]

The increase in chronic diseases of lifestyle including obesity, diabetes and hypertension, is receiving greater attention by the DoH. May 2005 was physical activity month, during which the DoH launched a campaign, '*move for health*', which aimed at promoting physical activity of any kind among all sectors of the population. While campaigns such as these have a place in the promotion of healthy lifestyles by creating awareness of the health risks of smoking, unhealthy diets and sedentary living, there is a need to enhance integration of health promotion into PHC more systematically and make health promotion far more intersectoral.

The key social determinants of health include low levels of literacy (especially among women), poor sanitation and inadequate nutrition. These factors are linked to poverty, and to address them requires commitment and collaboration among the relevant sectors at all levels of government. As pointed out by WHO Africa Region: "Poverty fuels the impact of these factors on health as it keeps people in poor health and poor health keeps people in poverty."[12]

Contribute towards human dignity by improving quality of care

Much was done to improve the quality of care in the health system during the period 1999-2004. This included the launch of a Patients' Rights Charter in 1999 and a national policy on quality in 2001. All provinces have developed provincial policies, established quality assurance units and most have instituted quality of care programmes that include

either internal or external reviews, and health worker awards programmes.

A national supervision system for PHC has been implemented. This will help to improve the quality of PHC services provided. However, without effective human resource planning, development and management, the quality of care provided will continue to be constrained. Other important issues in enhancing quality relate to improving governance, and strengthening PHC, EMS and hospital service delivery systems.

The activities for improving the quality of care outlined in the strategic framework will, if properly implemented, contribute a great deal in improving quality. These activities include strengthening community participation and improving clinical care at all levels of the system. Achieving these, especially functional community participation structures at the clinic level will require resources. Furthermore, it is fine for the DoH to talk about the 'Patients' Rights Charter' needing to become an advocacy tool for improvements in quality of care, and communities needing to be empowered regarding their rights,[13] but the actors in government need to understand the consequences of such empowerment. In particular, the conflicts that will invariably arise when community stakeholders pose challenges, need to be better managed than in the past. All stakeholders need to be prepared through appropriate training to ensure that community participation in health development becomes a reality. However, the national DoH's strategic plan for 2005/06-2007/08[14] is notably silent on this.

The need for community participation in health to be adequately resourced, is well documented in the public health literature, as is evidence of its contribution to improving quality and accountability in health care.

Another issue that needs more coherence is the use of accreditation to improve the quality of hospital care. Most provinces are using either external or internal methods of accreditation. However, national guidance and an assessment of what works and in which contexts may be necessary to strengthen through the use of accreditation.

Improve management of communicable diseases and noncommunicable illnesses

In this section the achievements, the key challenges and the adequacy of the plan to address these challenges are discussed for the following key programmatic areas:

- Child and youth health
- Sexual, reproductive and women's health
- HIV and AIDS
- Malaria and tuberculosis
- Mental health
- Nutrition
- Chronic diseases.

Child and Youth Health

There have been a number of successes in improving the care related to childhood infectious diseases. These include strengthening of the surveillance and management systems; improving the immunisation coverage, currently 82%, amongst 1 year olds; implementation of the Integrated Management of Childhood Illnesses (IMCI) strategy has been achieved in most of the health districts (46 out of 53); and expansion of the prevention of mother-to-child transmission (PMTCT) programme. The target set by the DoH of having 100% of health districts attain an immunisation coverage of at least 90% is realistic and achievable.

The DoH has come under much criticism for dragging its feet on the rolling-out of the PMTCT programme. However, PMTCT services are now available in more than 204 public hospitals and 1 055 Community Health Centres and clinics.[7] The programme aims at preventing transmission of HIV from infected women to their infants during the antenatal, intrapartum and postnatal periods, particularly during breastfeeding. It includes strategies such as short-term antiretroviral (ARV) prophylactic treatment; effective and safe infant feeding; and ongoing counselling and support. With its target achieved of having at least one service point per health district by March 2005,[15] and 100% of PHC facilities offering the service by March 2009, the DoH can be said to be heading in the right direction. However, recent criticism that children are not benefiting maximally from the Opererational Plan for Comprehensive HIV and AIDS Care, Management and Treatment needs attention.[16]

The DoH has also adapted the IMCI strategy, an integrated approach to reduce child morbidity and mortality, to include care of children born to HIV positive women including

ARV therapy for children. This together with the PMTCT programme, are key interventions to reduce infant mortality and are in keeping with strategies outlined by the Millennium Development Project.[17] However, this does not necessarily mean that the DoH will achieve the targets of the Millennium Development Goals (MDGs).

The DoH has identified full implementation of the IMCI strategy within the PHC approach as a key challenge since successful implementation of IMCI is crucial to reducing infant mortality. However, the strategic framework is not explicit on activities that would facilitate the strengthening of the community component of IMCI, neither does it set targets for achieving this. IMCI in the community has remained weak since the implementation of the IMCI strategy. To improve this will require greater attention in the detailed annual plan of the relevant directorate as well as greater resource allocation.

A significant achievement in promoting child and youth health has been the development of a school health policy with its implementation guidelines, and a Youth and Adolescent Health Policy, to provide strategic directions regarding the health care of school-aged children, youth and adolescents. The expanded life skills programme, of the HIV and AIDS cluster, at schools is an excellent strategy by the DoH to raise awareness of HIV and AIDS amongst learners in school. However, these efforts would be more sustainable if life skills were more effectively integrated and implemented in the Further Education and Training curriculum, for learners in grades 10 to 12. This will require much better collaboration between the Health and Education sectors in policy development, implementation, and monitoring and evaluation. These efforts should be complimented by evidence-based behaviour change programmes such as peer-based education and ongoing national condom social marketing programmes.

As with many of the priority programmes outlined here, the main challenge is to bridge the policy-implementation gap, an issue also raised by Buch[18] in a review of the previous strategic framework. A good starting point would be to strengthen collaboration and coordination among the various units, e.g. Youth Health and the HIV and AIDS cluster, within the DoH itself, as well as across departments such as health and education. To better monitor the implementation of these policies, stronger partnerships are required between the DoH and research institutions. Also required is improved allocation of resources for policy and operations research, and monitoring and evaluation.

The impact of health policies and other policies that affect health can be measured using infant mortality rates (IMR) and maternal mortality ratios (MMR). In her budget speech to the NCOP, the Minister of Health reported that in the 1998 SADHS the IMR was estimated at 45.4 per 1000 live births compared with an IMR estimated at 42.5 per 1000 live births in 2002.[19] When comparing estimates from the 1998 SADHS with the recently released 2002 SADHS figures, a decline in the MMR is also evident. There was a similar improvement in the MMR. In 1998 the SADHS estimated the MMR to be 150 per 100 000 deliveries, while the 2002 SADHS estimate was 123 per 100 000 deliveries.

Sexual, Reproductive and Women's Health

Key strategies to improve maternal and women's health and other sexual and reproductive health services have been implemented. These include:

- The implementation of The Confidential Enquiry into Maternal Deaths Report.[20]
- The implementation of the Choice on Termination of Pregnancy Act No. 92 of 1996 as amended.[21]
- The introduction of strategies and programmes to reduce the incidence of violence and rape against women (e.g. development of guidelines on the treatment of rape survivors).[22,23]

While there has been some progress e.g. in the reduction of maternal mortality from unsafe abortions by 2.5% between 1998 and 2001,[7,20] many of the areas related to improving women's health status need to be strengthened. These include for example, the training of doctors and forensic nurses to support survivors and victims of violence. Given the extent of the problem of violence against women and the burden on the health system, the targets set by the national DoH are disappointing. For example, the target of 100% of hospitals offering post-exposure prophylaxis (PEP) to women who have been sexually abused by March 2006[14] begs the question: *how many hospitals are currently providing such treatment, and if not, why not?* More attention and resources should be directed at addressing this problem than is currently the case. Additionally, better partnerships, and greater resource allocation to NGOs to assist the public health sector, are required.

There have been some efforts at improving cervical and breast cancer awareness and screening. However, much more could be done. The proposed target of 70% coverage of the target population for cervical screening by March 2009[7] will not be achieved without overall strengthening of the health system.

There is little doubt that maternal mortality could be reduced through better functioning referral systems and well-equipped and staffed maternity units and district hospitals. While there have been investments into strengthening midwifery care, through initiatives such as the training of advanced midwives, efforts to ensure the steady supply of professional midwives should be an integral part of the human resource strategy for the health sector. Professional midwives form the backbone of the district maternal health programme, and are central to reducing maternal morbidity and mortality. The proportion of births that were attended to by either a nurse or doctor, as pointed out by the Minister of Health in her budget speech recently,[19] has increased from 84% in 1998 to 92% in 2003. This is commendable and can be partly attributed to the policy of free health care for pregnant women.

It is disappointing that no mention is made in the strategic framework[7] of progress about mainstreaming gender in the health sector. However, it does provide a target for mainstreaming gender, which is 'the full implementation' of the national plan to mainstream gender by 2009. The plan however, is yet to be developed, and the stated target is excessively broad. Except for gender-based violence, little progress has been made regarding this important area, especially if the role of gender inequity in fuelling the HIV and AIDS epidemic is considered. This may be reflective of a general lack of capacity to deal with problems that require an integrated rather than a 'disease-oriented' approach. Alternatively, perhaps, too little effort has been placed on coordination and collaboration across the different clusters in the DoH and developing shared strategies and targets. Given the established relationship between health and development, and the fact that achieving gender equality and empowering women constitutes one of the MDGs[24] this is an area that needs more attention.

HIV and AIDS

The 2004 antenatal prevalence survey revealed that the overall prevalence of HIV infection is increasing.[25] However, the national HIV and AIDS programme has not been well coordinated and national leadership in the fight against HIV and AIDS has been weak.

The South African National AIDS Council (SANAC) was established in 2000 but its performance to date has been disappointing. A recent study[26] on the institutional dynamics of South Africa's response to the HIV and AIDS pandemic included a review of SANAC, and indicated major problems with the Council, in particular with its structure and functioning. The key challenge for the next five years revolves around the implementation of the Operational Plan for Comprehensive HIV and AIDS Care, Management and Treatment (Operational Plan), including the scaling up of safe provision of antiretrovirals (ARVs) to those patients who qualify for them. To address this challenge requires a much stronger SANAC to coordinate, guide, monitor and evaluate the country's response to the epidemic.

Another key challenge in scaling up treatment is to ensure that prevention efforts do not lose momentum. Indeed, prevention efforts need to be intensified. For this to happen strong leadership is required as well as for the development of innovative approaches, interventions, and research to mitigate stigma and gender oppression and barriers to accessing Voluntary Counselling and Testing (VCT).

The provision of home and community-based care has been strengthened significantly. The number of programmes have increased from 466 in 2001/02 to 892 in 2003/04 and have over 50 000 beneficiaries.[7] The envisaged introduction of a Community Health Workers (CHW) programme will help to strengthen both the HIV and AIDS, and the tuberculosis programmes, especially around adherence to treatment. However, the human resources plan has yet to be developed and effective coordination of home and community-based care will require considerable effort by the DoH to strengthen collaboration with the Department of Social Development.

It is apt to reiterate the importance of the overall strengthening of the health system in order to achieve the MDGs. This is especially relevant to the sixth MDG of preventing the spread of HIV, malaria and tuberculosis as well as access to essential medicines.[17] The challenges posed to improve the overall health system by the HIV pandemic are shared with other health priorities, such as TB, malaria and maternal and child health. Four elements in particular need attention:

- training and retention of human resources;
- information systems;
- a regular and well-managed supply of drugs and other supplies; and
- infrastructure.

In essence, a functioning DHS will be required to achieve and sustain many of the MDGs related to health.[27]

Malaria and Tuberculosis

Significant successes have been reported with both decreasing malaria cases and deaths, with a case fatality

of <1% for the past 5 years.[7] The DoH has attributed this achievement to the success of the vector control programme and the collaboration with Mozambique and Swaziland.

The TB control programme has had limited success, in part due to its relationship with HIV infection. The current cure rate for TB is 53.8%, whilst the target for December 2003 was 85%.[7] Key challenges identified are ensuring the quality of the DOTS programme and the provision of nutritional supplementation to TB patients. However, what received no attention in the strategic framework was the outline of a strategy on how the sectors would work together to address, in particular, the problem of TB and HIV and AIDS.

The DoH by its own admission, will not reach the targets set for its TB Control Programme. The Minister recently announced four strategies to be adopted to strengthen this programme.[7] These include:

- appointment of TB coordinators in each health district;
- strengthening the laboratory system;
- strengthening the implementation of the DOTS strategy; and
- mobilisation of communities to assist patients to complete their treatment.

What appears to be missing is the acknowledgement that TB is a disease of poverty. It therefore follows that a more intersectoral approach is needed to prevent TB and address its root causes. There is sufficient evidence in the public health literature that almost any intervention that reduces poverty will also decrease the disproportionate vulnerability of poor people to disease, including TB.[28,29]

Mental Health

Significant achievements here have been the promulgation of the Mental Health Care Act,[30] with the significant policy shift of integration of mental health into PHC services. However, due the unavailability of adequately trained personnel, and sustained and committed leadership at all levels of the system to facilitate the integration of mental health into the PHC services, this shift has not been achieved. The regulations have been published but changes are needed[b] and the proper implementation of the Mental Health Care Act is thus important work that remains. Given the links between HIV and AIDS and mental health,[31] one is tempted to say that the target of 100% implementation of the Act *only by 2009*, while probably realistic, is indicative of just how much effort needs to go into strengthening the NHS.

b Personal communication: Prof. Freeman - Chief Specialist, SAHARA HSRC and former Director for Mental Health, DoH.

Other achievements in the area of mental health include:

- The drafting of regulations to restrict advertisements of alcohol and the introduction of warning labels on the harmful effects of alcohol.
- The implementation of violence and suicide prevention programmes for schools, including a suicide toll free line and public awareness programmes.

However, key challenges remain for mental health and substance abuse control. These include stronger leadership and better coordination of mental health programmes within the DoH in general, and better collaboration and integration of efforts with other government departments, in particular the Departments of Education, SA Police Services, Social Development, and Justice.

There have been recent media reports of abuses of psychiatric patients in some public psychiatric hospitals including Townhill and Fort Napier Hospitals in Pietermaritzburg.[32] It is noteworthy that the DoH acted swiftly with a ministerial visit and the institution of a commission of inquiry into the allegations. Although the Mental Health Care Act was drafted to ensure that the rights of patients are protected; the Act has not yet been fully implemented. This may constitute one example of the lack of capacity referred to by the President.

Nutrition

The high levels of wasting and stunting established by the national Food Consumption Survey[33] led to the implementation of a series of strategies by the DoH to improve nutrition. These include:

- the fortification of maize meal and wheat;
- promotion of exclusive breastfeeding; and
- the implementation of food-based dietary guidelines.

Furthermore, a range of strategies were implemented to promote poverty alleviation and food security, and the comprehensive management of malnutrition. These include:

- the implementation of the integrated nutrition programme (INP);
- the promotion of community-based growth monitoring; and
- development of community gardens.

A review of the implementation of the nutrition policy, highlighted important steps that need to be taken to reduce hunger and malnutrition.[34] These include giving the nutrition

directorate the necessary resources to address the lack of capacity. This highlights again the crucial gap between successful policy development and implementation, and emphasises the importance of setting realistic objectives and providing appropriate resources to ensure success.

Steyn and Labadarios have also noted with disappointment that many of the excellent recommendations made by an earlier survey[35] have not been implemented, especially those related to the targeting and coverage strategies, which still remain a problem at both school and geographical level. This indicates a poor use of research findings by policy makers, an area that needs attention if evidence-based planning is to be improved within the DoH.

While key nutrition related policy documents have been developed in the past five years (e.g. development of national nutritional guidelines for people living with TB, HIV and AIDS and other chronic debilitating conditions), it is clear that more intensive efforts to scale up implementation are required to reduce wasting, stunting and the high rates of malnutrition. The DoH aptly lists the key strategy of improved household food security, in collaboration with other government departments and civil society partners.[7] To achieve this, however, would require strengthened intersectoral action at all levels, and effective monitoring and evaluation of programmes implemented. These are areas in which the DoH is still currently rather weak.

Chronic Diseases

The burden of disease from chronic diseases is on the increase in SA and internationally. National guidelines for the management of hypertension and diabetes are being implemented in health facilities. The National Cancer Control Programme has been strengthened with the introduction of the cervical cancer programme in 2000 (albeit with the limitations pointed out earlier). The Cancer Control Programme will benefit from the envisaged plans to strengthen health systems, in particular the strategy to strengthen the human resources for health.

In concluding this section, it can be said that while much has been done by the DoH to reduce morbidity and mortality, the main challenge is to address threats arising from HIV and AIDS and TB. A number of specific strategies to improve access to services, and the quality of these services, provided in the public health system is thus needed. Also required are cross-sectoral strategies such as improving basic literacy, improved quality of education, household food security and improved nutrition, and adequate sanitation and clean water.

Strengthen PHC, EMS and hospital service delivery systems

One of the key commitments of the RDP was to improve access to clinics in the rural and under-served areas. In the past ten years 1 345 new clinics were built and a further 263 were upgraded. Although most clinics have reasonable infrastructure in terms of sanitation, water, electricity and telecommunications, about 10% of clinics do not have sanitation, electricity and telecommunications, while 20% of clinics do not have piped water.[7] These pose significant risks to the adequate provision health care.

Challenges are most notably those related to human resources. For example, only about 40% of facilities have trained primary health care nurses.[7] Some provinces face serious problems in terms of personnel shortages and the inability to recruit and retain skilled personnel by far is the biggest constraint on effective health care provision in the public sector. This is explored further in the section on human resources. There is also the challenge of inequitable distribution of health facilities and some provinces have health service infrastructure backlogs.

On governance issues, the functional integration between provincial and municipal health services (MHS) has been implemented in some provinces, but many challenges remain. Key challenges with respect to PHC and the DHS include:

- finalisation of the funding of MHS;
- provision of full funding for primary health care based on the cost of provision of a package of PHC services;
- elimination of fragmentation of services provided by provinces and municipalities;
- strengthening of quality of care at PHC level; and
- strengthening of community participation in the governance of PHC services.[7]

There have been recent media reports that municipalities in various parts of the country intend to stop funding personal primary health care services, especially in the Western Cape and Gauteng. To ensure that PHC delivery in metro and large municipal areas where a significant amount of PHC services are funded and rendered by municipalities do not collapse, the DoH, National Treasury and the Department of Provincial and Local Government need to resolve the issue of replacement funding for PHC services. Given the centrality of PHC services to the health system the possibility of ring

fencing PHC funding in each province should be urgently considered.

Revitalisation of public hospitals

An audit of the hospital infrastructure in 1996 found that one third of the hospitals needed replacement with a further third needing upgrading. The DoH responded to these findings with a number of initiatives and considerable financial investment. These include:

- building of 18 new hospitals and upgrading of another 190 since 1999;[7]
- the hospital revitalisation programme which currently focuses on improving the infrastructure, equipment, management and quality in 27 hospitals; and
- the Integrated Health Planning Framework (IHPF) is being developed, and will provide a planning tool to determine the shape and size of the health system for the next 10 years.

Despite these achievements, a series of challenges remain. Hospital care needs to be accessible, of good quality and affordable. The implementation of public-private partnerships (PPPs) and social health insurance (SHI) will make this even more important to attract private fee-paying patients into the public sector.

The IHPF needs to be finalised and applied in each province to determine the size and shape of the hospital system against affordability targets. Hospitals need to be revitalised at a much faster pace, including improvements to the infrastructure, management, equipment and quality. The governance role of hospital boards needs to be strengthened to ensure that this happens. The national DoH strategic plan[14] is, however, not explicit on how it is going to strengthen the performance of hospital boards.

Even though four new hospitals were completed in 2004/05, this must be considered a small number given the large number of public hospitals in the country in need of revitalisation. Officials from the DoH recently informed the parliamentary portfolio committee on health, about the reasons for slow progress in the implementation of the revitalisation programme. Many of them relate to problems in provincial public works departments and the lack of capacity of small and medium size enterprises to complete work within the contract period. It is certain that people dependent on the public hospital system as well as health workers would appreciate acceleration of this programme.

Strengthen support services

A number of initiatives have been implemented to strengthen support services. The national health information system (NHIS), which is critical for monitoring the performance of the health system, has been strengthened in a number of ways during the past five years. However, the implementation of the NHIS has been uneven, with provinces implementing the system in selected hospitals only. The minimum data sets for primary health care have been implemented with more success, with over 98% of PHC facilities reporting data monthly.[7] However, the quality of the data and its use by managers and clinicians is poor. This is largely due to the intractable human resource problem in the health sector.

Better progress has been reported with respect to the strengthening of laboratory services, especially, in the context of the implementation of the Operational Plan. Every health district now has access to services for viral load assessments and for CD4 counts.[7] However, similar progress is needed in order to reduce the turn around time for TB sputa results.

The pharmaceutical supply management has also improved with surveys suggesting that more than 80% of Essential Drug List drugs are available at PHC facilities. Reliable provision of essential drugs is an important indicator of the effectiveness of the health system. However, there are concerns over the recent media reports that clinics in the Buffalo City municipalities ran out of chronic medication.[36]

Human resource planning, development and management

The most critical resource constraining government's ability to deliver on its stated targets for the health sector is the availability and capacity of skilled personnel. A strategic framework on human resources for health is currently being finalised.

A number of strategies have been outlined in the strategic plan[14] to address the quality, supply and distribution of health personnel in the country. These include:

- the development of a skills development policy and programme by March 2006;
- the development of a strategy for the retention of skilled managers and specialists;
- the development of a cadre of mid-level health workers (medical assistants); and
- the implementation of a community health worker programme.

However, the targets outlined in the strategic plan[14] are hopelessly inadequate given the gravity of the human resource problem in the health sector.

The shortage of pharmacists in the public sector, and rural areas in particular, is a national problem that needs to be addressed. This is especially important to ensure the roll-out of the antiretroviral therapy (ART) component the Operational Plan. This shortage is not addressed in the DoH's strategic framework.[7]

It is expected that the Human Resource Framework that is currently being finalised will be used to develop a Human Resource Plan for the country and hopefully address this problem. While these developments in human resource planning are welcomed, it might be argued that this is too little, too late. Since human resources are the backbone of the health system, this issue needs to be treated with far more urgency.

Planning, budgeting and monitoring and evaluation

The first ever National Health Accounts report was completed in 2000, and public health expenditure reviews were conducted in 2001 and 2003.[7] Whilst the interprovincial equity gap has been closing over the past five years, four provinces are still below the national average, namely the Eastern Cape, North West, Mpumalanga and Limpopo. Addressing intra-provincial inequities needs concerted action, as does funding for PHC services.

The progress on SHI has been slow for a number of reasons. These include the financial implications and sustainability of a SHI scheme. Without the implementation of SHI, it is unlikely that there will be much progress in reducing the inequities between the public and private health sectors. For more details see chapter three in this Review. According to Government's May 2005 report on its Programme of Action,[37] additional work is being done to assess the financial and fiscal implications of SHI, including the Risk Equalisation Fund. A report on this work is expected in June before decisions can be made by the Cabinet.

The monitoring of progress in reducing inequities, as well as progress towards the achievement of the MDGs, is critically dependent on an adequate health information system. The compilation and analysis of data, timeous reporting and effective use of health information are key pillars of effective health policy development, planning and management. The lack of reliable, up to date information has significantly reduced the capacity of the health sector to monitor the health of the population and the evaluation of the overall performance of the health system.

While the government has made a huge investment in the development of a health information system (HIS) in the past eight years, this has largely been focused on the tertiary hospitals, with little financial resources committed to the development of an effective District Health Information System (DHIS).[38] The development of an effective DHIS was further constrained by the lack of adequate skilled human resources at the district level. Having these human resources in place is vital to building a strong DHIS, and also crucial to the effective planning, implementation, monitoring and evaluation of PHC services in the district.

Prepare and implement legislation

Significant pieces of legislation were prepared for debate and adoption by Parliament during the past term of government. Examples of these are:

- Tobacco Products Amendment Act of 1999[39]
- Medicines and Related Substances Amendment Bill 40 of 2002[40]
- Mental Health Care Act No. 17 of 2002[30]
- National Health Act of 2003.[11]

Key challenges for the next five years include:

- Passage and implementation of the Traditional Health Practitioners Bill;[41]
- Finalisation of regulations and implementation of the Mental Health Care Bill;[42]
- Finalisation of the draft Nursing Bill[43] and facilitation of its passage by Parliament;
- Facilitating the passage of the Tobacco Products Control Amendment Bill[44] and monitoring compliance with its provisions; and
- Completion of the drafting of legislation that will transform the statutory councils. For more details on legislation, see chapter two in this Review.

While there have been many achievements in the area of legislation, the absence of legislation on SHI is a significant gap. Social health insurance is a key strategy in health care reform towards greater equity in health care coverage. But as pointed out by Buch[18] "..unless there is an assurance that SHI income will not be subtracted from tax-based funding,

there may be little net real increase in funds for health".

The most significant milestone was the proclamation by the President of the Health Act,[11] in May 2005. Whilst most sections of the Health Act are now in effect, the provisions that deal with the certificate of need and the chapter that deals with human tissue and organs will come into effect later. Like the implementation of the Mental Health Care Act, implementation of the Health Act will pose challenges if there is no coherent implementation and communication strategy to guide it.

Strengthen international relations

In her budget speech to the NCOP on 1 June 2005 the Minister of Health was highly complimentary of the DoH's international role. She cited, in particular, her role in mobilising support for a resolution on international recruitment and migration of health personnel during the World Health Assembly held in May 2005. She also noted the need to finalise an action plan for cooperation between SA, India and Brazil, and listed a number of other countries with which SA has bilateral relations of various kinds including Nigeria, Sudan and Mozambique.

Despite achieving democracy over 10 years ago, in many aspects developed countries are still keen to expand bilateral relations and provide donor assistance. On the other hand, developing countries see SA as a leader on many issues, and wish to establish bilateral relations with SA too. However, the capacity of the DoH in particular, and the NHS in general, to absorb and utilise new resources as well as provide support to other developing countries, is a key limiting factor to our ability to further strengthen international relations.

Conclusion and Recommendations

The key challenge facing SA, as outlined by its leadership, is the establishment of a model developmental state. Taking Evan's definition of a developmental state, this translates to the creation of a strong, efficient and effective bureaucracy. The question posed by the President is – "do we have the cadre of civil servants that are able to rise to this challenge?" This is the question to which the FOSAD is attempting to respond. Our main task in this chapter has been to reflect specifically on the capacity of the health bureaucracy to meet the health challenges as they relate to a developmental state. A central question has thus been *which priorities should drive the agenda of the health sector in order to achieve the MDGs and the President's vision for a developmental state?* We conclude this chapter with some suggestions.

Firstly, it requires that health personnel take the challenge seriously, and commit themselves to acting in ways that will push forward the agenda of the leadership. This in turn will require that political leaders as well as managers in the health system are able to clearly articulate and communicate a vision and a mission that resonates with front line health workers. This vision and mission for the health system must be translated into clear operational strategies.

Secondly, it needs a programme of action that is developed with and that captures the imagination of those charged with its implementation. In a recent issue of the Harvard Business Review, a useful distinction was made between traditional models of change and one called a 'positive deviance' approach to change.[45] While the former is characterised by top down leadership, the latter focuses on community ownership of the change process. In our context, this could translate to greater empowerment of leaders at the local level to drive the change agenda. This is possible if the vision and mission are clearly defined, and a shared understanding thereof prevails among leaders and managers at all levels of the system.

The third crucial ingredient that is necessary for the building of a developmental state is an effective governance and management system. As stated earlier, there are several challenges in the current governance and management arrangements. The implementation of the provisions of the Health Act may provide the space needed to critically review and build systems that will strengthen implementation of the already adopted health policies. Alternatively, the provisions may consolidate and rigidify a system that does not work optimally. Additionally, mechanisms and structures to facilitate community participation, especially of poor and marginalised groups, should be nurtured and adequately resourced to strengthen accountability in health care. An accountability-oriented health system that encourages the poor to claim their right to health care (and to other conditions that promote health), can have positive effects on social and economic growth, and be a vehicle for fulfilling rights, for active citizenship, and development.[46]

The fourth necessary ingredient is a critical mass of skilled and motivated health managers and health workers at all levels of the health system. The need for urgent steps to produce and implement a strengthened national human resources plan for the health system has been noted

in the section on human resources. What is needed, is for the NHS to be seen as an employer of choice for the large numbers of health workers needed, including those needed to live and work in rural areas of the country. This implies that government has to address the low wages of nurses in particular, as well as other manifestations of poor supervision and human resource management, which lead to demoralisation. Furthermore, it implies that government as a whole needs to make 'country-living' desirable. This can only be achieved by greatly increasing investments in these areas by improving the road infrastructure, schools, health facilities and recreational facilities in rural areas. Such a strategy will also contribute to the improvement of the quality of life of the local residents and may play a part in slowing migration to urban areas.

In concluding, it is appropriate to refer to the Declaration of Alma Ata[47] and its articulation of a comprehensive PHC approach as the strategy to achieve 'Health for All'. The National Health Policy for a District Health System was based on the vision of the Alma Ata Declaration, and the National Health Plan of the African National Congress[8] as well as the Health Act,[11] firmly establishes PHC and the decentralisation of services through the DHS, as central tenets of the health system. As originally outlined in the Declaration of Alma Ata, addressing the main health problems (which today includes HIV and AIDS) means that health has to be considered in the broader context of its contribution to, and promotion by, social and economic development, and requires integrated health systems, strong intersectoral collaboration, community participation and political will. To ensure that PHC service delivery in metro and large municipal areas do not collapse, the DoH and National Treasury and the Department of Provincial and Local Government need to resolve the issue of replacement funding for PHC services. Given the centrality of PHC services to the health system, the possibility of ring fencing PHC funding in each province should be urgently considered.

Like the Declaration of Alma Ata, more recent documents Word Bank Report,[48] WHO, 2001,[49] UN Project, 2005,[17] also remind us that health is integrally linked to the full range of development challenges – food security; education, gender equity, water and sanitation, and poverty reduction. Indeed, the World Bank Report (1993) clearly indicated that investing in health is one means of accelerating development and that the cost of ill health impedes development initiatives. More recently, the Report of the Commission on Macroeconomics on Health[48] again emphasised that:

"Improving health...of the poor is an end in itself, a fundamental goal of economic development. But it is also a *means* (original emphasis) to achieving other development goals related to poverty reduction."

The President's call for a developmental state and the need to scale up service delivery in order to address the challenges of the "second economy" through a "programme of skilful social support of health care, education and other social arrangements"[50] seems to concur with the views of other development theorists.[27,51] In a recent article in the Lancet, Sachs and McArthur[27] suggested a few reasons why some regions are falling short of meeting the MDGs. Among other, they cite:

> *"The pervasive problem of poverty traps, in which poor people are simply too poor to carry out the investments needed to overcome hunger, disease, and inadequate infrastructure, and as a result they are unable to achieve sustained economic growth."*

The key to ending the 'poverty trap'[50,51] is to facilitate the 'support-led' development that the President has referred to[50] by investing in health, education and other social arrangements. This requires that the state builds a bureaucracy that is efficient, and in particular, a health system that delivers.

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