Twenty years of the South African Health Review

Authors:

Peter Barron[i]

Ashnie Padarath[ii]

The year 2017 marks the 25th anniversary of Health Systems Trust and the 20th edition of the Trust's flagship publication, the South African Health Review (SAHR). First published in 1995, the original intention of the SAHR (as it has commonly become known) was to systematically pull together information on health from as many sources as possible; to describe and critique policy initiatives to serve as a basis for gauging whether there has been successful implementation; and to help define a policy research agenda by highlighting policy thrusts.[1]

Over the past 20 years, the SAHR has assiduously chronicled developments in the South African health system. It has curated knowledge from a wide spectrum of sources in order to provide the necessary information to assess progress in transformation of the health system since 1994 and has reflected on successes, failures and missed opportunities. During this time, the focus of the SAHR has shifted from the need for policy development, to analysis of policy implementation and the health system's state of readiness to respond to policy reforms.

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i   School of Public Health, University of the Witwatersrand, Johannesburg
ii   Health Systems Trust

Introduction

The *South African Health Review* (SAHR) is now widely recognised as one of the most authoritative sources of commentary on the South African health system. It is widely used in teaching public health at undergraduate and postgraduate level in South Africa, and it is used by scholars, donors, journalists, policymakers and policy-implementers at various levels of the health system.

The initial edition of the *SAHR* was based on commissioned chapters relating to the most important health policies, reforms and priorities of the time. The chapters were reviewed first by an independent reviewer and the overall composite edition was reviewed by a committee. To a great extent, this initial publication created the framework for subsequent editions. However, there have been a number of important changes and improvements over the 20 editions.

There has been a move away from commissioned articles to an open request to all authors writing on themes pertinent to the health system in South Africa. The process of peer review has been improved, with at least two independent reviewers assigned to each article, as well as comment from an editorial advisory committee. In 2014, the *SAHR* was accredited as a peer-reviewed publication by the Department of Higher Education and Training. This has raised the profile of the *SAHR* and offers a particular incentive to academic contributors, as peer-reviewed publications are one of their key performance areas, and they can receive subsidy allocations for their contributions.

In 2012, Health Systems Trust (HST) introduced the Emerging Public Health Practitioner Award to commemorate the its 20th anniversary. This is a widely advertised open competition in which young health practitioners submit articles they have written. The article assessed by the Editorial Advisory Committee to be the best (against a set of criteria) is published as a chapter in the *SAHR*.[2-5]

The *SAHR* has recorded the maturation of the health system through a series of reforms geared towards realisation of primary health care (PHC) as the primary mode of healthcare delivery;[6] the preparation of the health system for the introduction of National Health Insurance[7] (NHI), and the achievements towards attaining the Millennium Development Goals[8] and the current Sustainable Development Goals.[9] It has also documented many of the initiatives aimed at realising these reforms and goals.

In addition to providing information and discussion on the latest policy debates, over the years the *SAHR* has captured perspectives on a range of programmatic activities designed to consolidate health system strengthening. These include issues encapsulated in the Minister of Health's Negotiated Service Delivery Agreement[10] related to increasing life expectancy, decreasing maternal and child mortality, combating HIV and AIDS, and decreasing the burden of disease from TB. They also include exploring possibilities for collaboration with the private sector[11] and harvesting of promising models, good practices and lessons to inform further implementation and scale-up.

South Africa's commitment to re-engineering the health system has been driven by the country's quadruple burden of disease, which has been fuelled by a range of risk factors including unsafe sex and sexually transmitted infections;[12] interpersonal violence and alcohol abuse;[13] poor diets;[14] and maternal and childhood malnutrition.[15,16] The high prevalence of these and other risk factors, and the health sector's responses to them, have been captured in the *SAHR*. In many instances the *SAHR* has sought to apprise its readers regularly of progress in tackling these issues. Other significant themes covered recently include the social determinants of health,[17] reproductive health,[18] mental health,[19] disability,[20] climate change,[21,22] and occupational health.[23]

Due to the volume and complexity of information it is not possible to synthesise all the important issues addressed in the *SAHR* over the 20 years. However, the remainder of this chapter is devoted to covering the important touchstones featured in the *SAHR*, based on the World Health Organization's six 'building blocks' for an effective, efficient and equitable health system.[24] Selected examples have been chosen for each of the major building blocks (Figure 1) to illustrate how the *SAHR* has reported on these issues over the past two decades.

Figure 1:   World Health Organization's Health Systems Framework
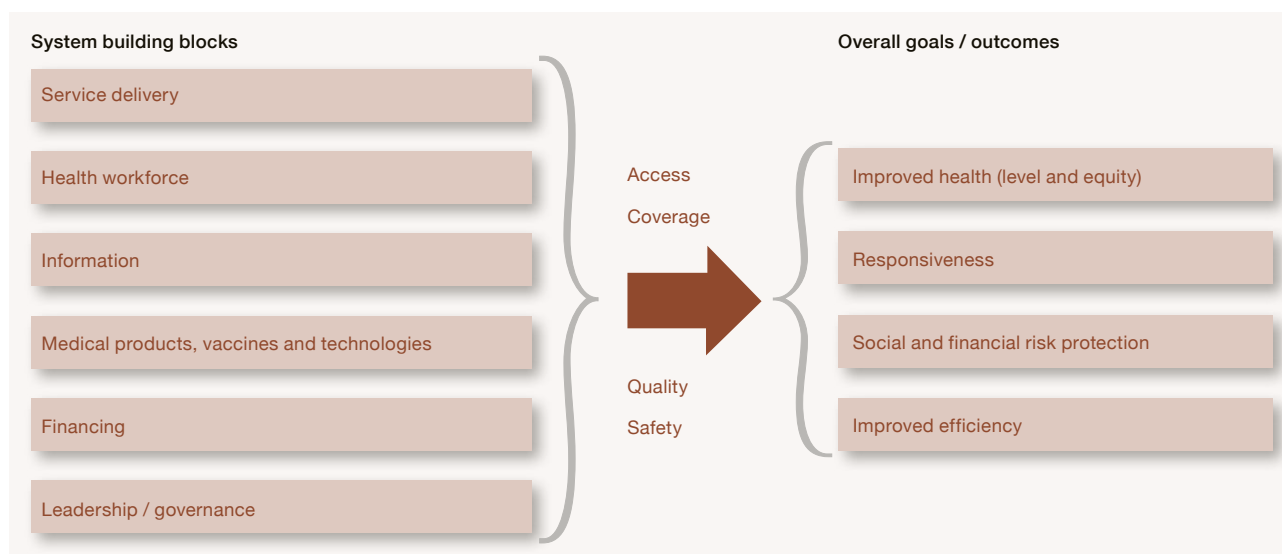
Source: World Health Organization, 2007.[24]

Leadership and governance

In the first edition of the *SAHR* in 1995, a number of important issues on leadership and governance were highlighted by Steve Tollman and Laetitia Rispel in their chapter titled "Organisation, planning and governance".[25] These issues included tension between the national and provincial Health Departments; the central importance of the district level in the health system; the relationship between local government and the district health system; and the danger that "preoccupation with organising … the provincial health office … will obstruct rather than facilitate a desperately needed, planned and sustained process of empowerment at district level". Another challenge identified was that policy formulation was distant from the sites of planning and delivery, with the authors calling for a process that "blends top-down expertise with bottom-up experience and expertise".

Twenty-one years later, in the 2016 *SAHR*, Rispel[26] suggested that notwithstanding progress made since 1994, the South African health system has seen relatively poor performance compared with countries of similar income level and given the country's quantum of healthcare spending. Problems similar to those described in 1995 are still being experienced, the major difficulty being a disconnection between progressive policies on the one hand – such as a PHC approach combined with legislation, policy and resource allocation aimed at achieving transformation and improved population health – and implementation on the other. Rispel identified three major fault lines in implementation: tolerance of ineptitude, as well as leadership, management and governance failures; lack of a fully functional district-health system as the main vehicle for PHC delivery; and inability or failure to deal decisively with the health-workforce crisis.

Over the years, several chapters in the *SAHR* have attempted to unpack the leadership implementation and operational challenges at district level.[27–29] For example, in 2014, Wolvaardt et al.[30] identified the key constraints and challenges that hamper district-management teams in effectively translating national policy into district-specific strategies, comprehensive work-plans and well-constructed budgets. According to the authors, some of the specific institutional design blockages are that district management has no influence over policy directives; strategy is designed at national and provincial level; district management has limited influence over the allocated budget; district management does not control workforce planning and appointment of staff; and there is no clear system whereby lessons learnt at district level are used to influence policy or strategy. In other words, the district health system is neither responsible nor accountable for performance. In addition, senior management fail to use evidence obtained from district level to modify policy to fit the reality on the ground. However, the authors also found that district managers conceded that "managers do not consistently and effectively use data for evidence-based decision-making, particularly with regard to planning and performance management".

Linked to this is the need to ensure that district management staff are supported. The *SAHR* has provided examples of local initiatives and in the 2014/15 edition Susan Cleary and colleagues[31] reported on the outcomes of a series of sub-district engagements to understand and strengthen community participation, and concluded that 'intangible software' such as values, power and communication, are important for enabling change and fostering better community participation.

Although not part of this *SAHR*, the Life Esidimeni tragedy of 2016 starkly highlights the governance and management failures in the Gauteng Department of Health, with the highest levels of management clearly shown to have ignored available evidence. In the words of the ombudsman, "The decision was unwise and flawed, with inadequate planning and a 'chaotic' and 'rushed or hurried' implementation process".[32] Most of the other provinces have also made the pages of the public press for reported mismanagement of their hospitals and finances.[33–36]

Health workforce

Over the years, human resources (HR) has been a perennial theme in the *SAHR* and every edition has featured at least one chapter on aspects of this topic. In the first edition of the *SAHR*, William Pick's analysis highlighted the maldistribution of health professionals between the private and public sectors, as well as the maldistribution of public-sector health professionals between the provinces.[37] It was estimated that in 1992/93, most of the highly trained professionals, including 93% of dentists, 89% of pharmacists and over 60% of all doctors, were working in the private sector. In the public sector, the Western Cape was found to have more than four times as many doctors per 100 000 population as Mpumalanga, and more than five times as many pharmacists per 100 000 population as Limpopo. The chapter also highlighted the need for greater support of health workers so that they would be "caring and compassionate", and the need for a patient's charter.

Since then, the *SAHR* has published numerous articles on issues as diverse as community service,[38] community health workers (CHWs), the Human Resources for Health Plan,[39] task-shifting, and mid-level health workers. Writing in 2005, Irwin Friedman[40] reported on the national CHW policy framework, which provided an outline of what was envisaged for a future national CHW programme. Today, CHWs are seen as a key component in the PHC Re-engineering Strategy[41] and feature prominently in the health chapter of the National Development Plan.[42] However, there remains a paucity of information on CHWs. For example, a chapter in the 2013/14 *SAHR*[43] pointed out that "despite the recognition that community health workers are a critical resource for comprehensive primary health care, there are few data available on their deployment in South Africa at present". While such official information remains incomplete, the *SAHR* has sought to feature examples of good practice and promising local interventions. Also in the 2013/14 *SAHR* for example, Padayachee and colleagues described a successful scale-up of the Ward-based Outreach Teams comprising CHWs in the North West Province,[44] with salutary lessons for other CHW scale-up initiatives in the country.

The 2016 *SAHR* featured a chapter on the potential of the public-health workforce to monitor the progress of NHI and the Sustainable Development Goals, to identify health-service priorities, and to implement effective delivery strategies. The chapter suggested that existing public-health units in the Western Cape and Gauteng, staffed with multi-disciplinary teams of public-health medicine

specialists and other public-health professionals, could be replicated across the country as a resource for health-system development and restructuring.[45]

The need to pay greater attention to HR data and information systems has also been identified as a key issue, with planning and monitoring of HR reflected in various editions of the *SAHR*. For example, as far back as 2010, Day and Gray[46] reported that "the registers of the various councils such as the Health Professions Council of South Africa, the South African Nursing Council and the South African Pharmacy Council include professionals who are retired, overseas, working part-time, working in other sectors or not working at all. In general, the registers do not have reliable information on how many people fall into these categories or on the proportion working in the public/private sectors, or on the distribution working part-time or across sectors". The authors reported that other poorly documented areas were the number and distribution of CHWs, allied health professionals and traditional healers.

Clinical associates have been used extensively in many sub-Saharan countries. Yet despite the chronic shortage of medical personnel in the public-health sector in South Africa, the number of clinical associates registered with the Health Professions Council of South Africa remains low, with only 130 of the 220 on the register employed in the public sector in 2013.[47] Mid-level health workers are ideally suited to 'task-shifting', which was described in relation to mental health in the 2014/15 *SAHR*.[47] Also known as 'task-sharing', this is defined as "involving the rational redistribution of tasks among health workforce teams. Specific tasks are moved, where appropriate, from highly qualified health workers to health workers with shorter training and fewer qualifications, in order to make more efficient use of the available human resources for health".

The 2014/15 edition of the *SAHR* sounded a warning bell on the state of nursing in South Africa. The chapter[48] noted that while nurses make up the largest single group of health-service providers, and their role in promoting health and providing essential health services is undisputed, there remain a number of concerns regarding South Africa's nursing profession, which is described as "being in peril and characterised by shortages", with declining interest in the profession, lack of a caring ethos, and an apparent disjuncture between the needs of nurses on the one hand and those of communities served on the other. The authors identified critical issues to be addressed by health policy-makers and practitioners in order to revitalise the nursing profession; these include nursing education reforms; the participation of nurses in policy-making; casualisation of the nursing profession; ethics; quality of care; and the work experiences of nursing managers at PHC clinics. The authors also suggested that the nursing practice environment is fraught with resource, administrative and quality-of-care problems. According to them, this is being compounded by workforce concerns, namely "suitability of new entrants, admission and selection of nursing students, training, competence, and work ethos". They found that the practice environment is also influenced directly by agency work and moonlighting, which in turn contribute to "poor staying-power, low energy levels, abuse of leave, suboptimal nursing care, split loyalties and accountability, and erosion of professionalism". Some of these issues have been highlighted again in 2017, with lack of leadership and governance from the Nursing Council making news in the popular press.[49]

Despite the many steps taken to improve the availability and distribution of human resources for health in South Africa, Rispel reminds us that there is still much to be achieved and suggests that one of the major fault lines in the health system has been precisely this failure to deal adequately with the health workforce.[49]

Information

According the World Health Organization, "the goal of a health information system is often narrowly defined as the production of good-quality data. However, the ultimate goal is more than this – it is to produce relevant information that health system stakeholders can use for making transparent and evidence-based decisions for health system interventions".[50]

In their 1995 chapter on 'Informatics Support', Debbie Bradshaw and Lulamo Mbobo found that "whilst much data are collected, these are mostly not processed or not used at an appropriate level and [tend] to be of an administrative nature".[51] Other information-related issues identified by the authors included lack of district and provincial synthesis of information; lack of utilisation of information for management; and lack of feedback of information, with the result that local staff do not routinely assess the efficiency and effectiveness of their work.

The *SAHR* has consistently noted and captured the developments and weaknesses of our unfolding health information system over the years. In 2011, the chapter on 'Health information systems in South Africa' highlighted the importance of being able to access good-quality data housed in a single, comprehensive data repository for monitoring and evaluating progress towards attainment of health related goals.[52] Key developments aimed at strengthening the health information system in South Africa were also presented, including the development of a District Health Management Information Systems policy and future steps for strengthening the health information system.

In the 2013/14 *SAHR*, Masilela, Foster and Chetty[53] reviewed the adoption and initial implementation of South Africa's eHealth Strategy. The authors noted the centrality of the strategy in achieving a well-functioning, patient-centred, electronic national health information system based on agreed scientific standards of interoperability, thus improving the efficiency of clinical care, producing the indicators required by management, and facilitating patient mobility. Important next steps were noted, such as the establishment of a unique identifier for each patient, and the installation of patient-based information systems at all healthcare facilities.

In the following (2014/15) edition, Wolmarans and colleagues[54] described the first steps in the roll-out of the health patient registration system in 700 primary care facilities in the 10 pilot NHI districts. They reported that the complexities and challenges in moving South Africa to a modern-day eHealth system were enormous, but were being overcome.

In 2014/15, Vera Scott and colleagues[55] echoed the themes highlighted in the 1995 *SAHR* when they explored the nature of PHC facility level decision making in human resources management and quality improvement. They noted that despite the increasing emphasis being placed on automation of data collection and information systems, informal information and experience-based knowledge remain crucial in local decision-making. The authors

highlighted the supportive and complementary role that the use of both formal and informal information can play in assisting operational managers by suggesting that local information and experience-based knowledge supports managers in adapting and innovating locally to ensure successful policy implementation, while the use of formal information supports greater accountability in service delivery.

The 1995 *SAHR* included an annexure on health and related indicators, with nine rudimentary tables showing demographic, socio-economic, mortality and morbidity rates.[1] Over the years, the chapter on health indicators has developed into the single most comprehensive and authoritative set of health indicators in the country and has for many years formed the backbone of the *SAHR*, with the rhyming of 'Day and Gray' (the two main authors), associated with this. The chapter on health indicators in the 2016 *SAHR* made up a third of the total review and extended over 100 pages, with detailed indicators covering demography, socio-economic factors, health status, health services and health financing.[56]

The South African health system, like all modern health systems, functions suboptimally if management decisions (at all levels) are not based on objective evidence and information. There have been wide-scale improvements in both the quality and quantity of information available over the past two decades. An example of this is HST's *District Health Barometer*,[57] which makes available a vast range of cross-sectional and longitudinal information, with comparisons among districts and provinces on key health performance indicators. Despite these data being available, the comments made in the first *SAHR* about the lack of use of information by managers is still apposite in most provinces, districts and facilities around the country.

Service delivery

During the life of the *SAHR*, HIV has been the highest-priority preoccupation of service delivery. The last two decades have seen the rise, and further rise, of HIV. With this came the reversal of the health gains of the previous 20 years. Life expectancy plummeted, while maternal, child and infant mortality rates soared. Instead of improving our key health indicators and moving towards achieving the Millennium Development Goals, South Africa succumbed to AIDS denialism and moved backwards. Up to the 2016 *SAHR*, at least 28 chapters dealt with HIV and AIDS, while a further nine chapters related to its terrible twin, tuberculosis. HIV is used as the tracer condition to gauge the building block of health service delivery.

HIV has been a black cloud dominating the health landscape over the past 25 years. In 1995, Quarraisha Abdool Karim described the early stages of the epidemic, including that it was affecting young women more than young men; that the prevalence was doubling on a yearly basis; that there was a gradient of infection from the Western Cape (1.2%) to KwaZulu-Natal (14.4%); and that there was a great deal of denialism regarding HIV.[58] In 1995, HIV was made one of the Presidential lead projects in the Reconstruction and Development Programme, and the budget was doubled to R42 million.

In 2017 there are now more than seven million people in South Africa infected with HIV, with over half of these on lifelong antiretroviral therapy (ART). The antenatal HIV prevalence rate has stabilised at 30% over the past decade, with higher rates among older pregnant women and lower rates among younger women aged 15 to 24 years.[59]

In the 2012/13 *SAHR*, Francois Venter[60] wrote in respect of HIV: "The programme is now internationally recognised as successful and is responsible for recent dramatic improvements in South African life expectancy. However, the scale and cost of the programme have presented many challenges to the healthcare system and to funders". He concluded that "the ART roll-out has been a complicated and qualified success teaching us much about public health programmes that have grand ambition. Maintaining and improving the roll-out in the context of complicated policy and operational challenges will, however, continue to challenge us if we are to maintain this success".

In addition to the success with treating people infected with HIV, there has also been success in components of prevention. The three mainstays of biomedical aspects of prevention are the three Cs: counselling and testing for HIV, condoms and circumcision. As was highlighted in the *SAHR* 2010 by Nesri Padayatchi and colleagues, the HIV counselling and testing campaign was launched in 2010. Since then, around 10 million tests are done annually, as well as half a million medical male circumcisions, and 750 million male condoms and 25 million female condoms are distributed.[57]

Medical products, vaccines and technology

Medicines, vaccines and technology are key health system building blocks and hardware. However, there has been a tendency to neglect the importance of these elements and supporting processes when key health-system success factors are under discussion. There have been 10 chapters on pharmaceuticals and four on traditional medicines in the *SAHR* up to 2016.

In 1995, Folb, Valentine and Eagles[61] reported on the findings of the Ministerial Drug Policy Committee, including a costing structure for medicines in the public sector; an essential drugs list and its importance in underpinning comprehensive treatment guidelines; encouragement of the use of generic medicines; the introduction of a pricing committee to review drug costs; an examination of the functioning of the Medicines Control Council; and the incorporation of traditional medicines into the formal health sector.

In the 2012/13 *SAHR*, Bada Pharasi and Jacqi Miot[62] showed how "medicine selection in both the public and private sectors in South Africa has undergone significant transformation in the past 16 years". In the public sector, medicine selection follows international best practice by being in line with an essential medicines list and standard treatment guidelines, and there are expert review committees that advise the ministerially appointed National Essential Medicines List Committee.

In 2016, Bangalee and Suleman[63] showed that South Africa is a world leader in pricing policies and "has instituted various mechanisms to render the pricing of pharmaceuticals more transparent including the single exit price that clarifies the price at which a manufacturer or importer may sell a medicine".

It is a basic function of the health system to have appropriate drugs available to treat patients. Yet in the 2013/14 *SAHR*, Seunanden and Day[64] reported that: "Over the past three years, drug stock-outs of TB and ARV drugs in public health facilities have been emphasised in media reports in South Africa. Recent media coverage highlights the inadequate supply of TB and ART drugs in healthcare facilities (including provincial depots) in all provinces, with the Eastern Cape, Gauteng and Free State receiving the most

criticism". They also note that "the reasons for TB drug stock-outs are multi-dimensional and range from a shortage of human resources to a lack of communication between suppliers, depots and health facilities".

It is clear that the fundamentals have been put in place to ensure that coherent drug and medical products procurement and distribution systems function appropriately. However, each incident of non-availability of drugs or vaccines for a particular patient represents a failure of the health system as a whole. A decrease in the number of such events will be a key marker of the effectiveness of the current health public health system and the future system based on NHI.

Financing

In her chapter on 'Financing and Expenditure' in the 1995 *SAHR*, Di McIntyre showed that in 1992/93 an estimated R30 billion (8.5% of GDP) was spent on health in South Africa, with 38.7% being public sector spending and 60.8% being private sector spending. The chapter also noted the hospicentric nature of public sector spending, with 55% of all spending going to secondary (11%), tertiary (14%) and academic hospitals (30%).[65] Challenges identified in the 1995 *SAHR* included overall maldistribution between the private and public sectors (relative to the populations being served); the overall under-resourcing of the public sector; maldistribution of spending between geographical areas with relatively affluent (urban) areas receiving a greater proportion than poorer areas (rural, ex-homeland); and maldistribution between levels of care. Many of these problems still exist in 2017 and the policy on NHI is aimed at dealing with many of these.[66]

More recent editions of the *SAHR* have explored the implications of the introduction of NHI and PHC, among other things, on health financing. In the 2011 edition of the Review, Mark Blecher et al. noted that there was demonstrable commitment on the part of the South African government to increasing health funding levels to address the growing quadruple burden of diseases and to improve

the quality and structure of health services, but cautioned that key priority areas, such as non-communicable disease and child health, required improved costing. In 2016, the authors investigated HIV financing in South Africa and probed whether there was sufficient fiscal space to afford and sustain the expanded and rapid roll-out of antiretroviral treatment and prevention interventions needed to reach the UNAIDS 90-90-90 targets in the context of declining economic growth, the monetary constraints announced in Budget 2016, and diminishing donor funding. They concluded that while there were indications that introducing the HIV 90-90-90 targets would be challenging, these were nonetheless likely to be affordable and cost-effective if implemented in a phased way and if annual increments to government AIDS budgets are sustained. There has been a significant change regarding what the money is spent on. This is illustrated in the 2016 edition of the *SAHR*[67] which shows that spending on HIV increased three-fold in real terms from 2009 to 2016, with spending on the HIV conditional grant projected to be more than R20 billion by 2018 (Figure 2). District health services have also benefited and the proportion of the total health budget spent on these has increased from around 35% in 1996/97 to more than 45% in 2016/17. Over the same period, spending on provincial hospitals (secondary and tertiary) has decreased from around 27% to 17%, with central hospital spending fluctuating around 20%.

Discussion

This chapter used selected examples linked to the World Health Organization building blocks to contrast what was documented in the first edition of the *SAHR* in 1995 with what has been presented subsequently.

Clearly, there have been a number of major successes in the health system. Probably the most important has been the response to HIV, which has been instrumental in improving the key health indicators relating to death rates, life expectancy, and maternal, child and

Figure 2:   Government and donor funding for HIV/AIDS-dedicated programmes (R billion real 2014/15 prices)
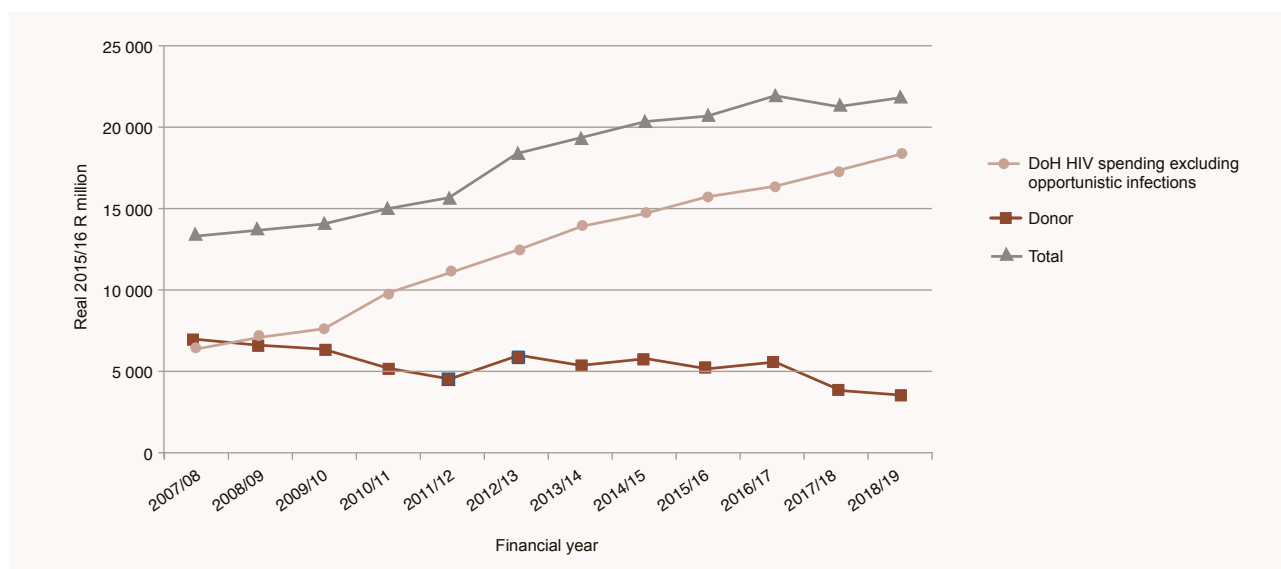
Source: Blecher et al. 2016.[67]

infant mortality. Nonetheless, it is also very clear that challenges remain and that much needs to be done to improve governance, leadership and accountability at strategic, district and facility level, as well as in terms of the overall planning and implementation of the health workforce. The National Health Act was promulgated in 2004, and in 2015 the White Paper on National Health Insurance was published. Both of these wide policy documents aim to remedy many of the challenges facing the health system in South Africa. However, the overarching challenge is how to implement the key policies successfully.

The *SAHR* has consistently noted that when policies are not complemented by adequate resources, committed leadership and stewardship, and regular engagement with key stakeholders, they will remain mere aspirations. Apart from implementing new policies and developing fair financing arrangements, there is also a need to focus on softer issues such as leadership and management, and to ensure that we build and nurture a cadre of health managers who are capable, empowered and motivated. Equally, in contemplating health-sector reform, it will be necessary to ensure accurate data on health status and health services to inform policy decisions, and to ensure that they emanate from a sound evidence base and contain information for a single health system incorporating both the public and private sectors.

Evidence of impact

Generating information for planning, monitoring, evaluation and decision-making is one of HST's key activities. One of the ways in which we do this is to share and curate both the implicit and tacit knowledge acquired in the re-design of our health system.

However, translating evidence into policy and practice and the gap between what is known and what is done (the 'know-do gap'), persists to such an extent that it has been described as a "chasm".[68] For example, it has been pointed out that it took 200 years from the time that a cure for scurvy was found until the cure was adopted by the British Navy, to illustrate the challenges involved in moving knowledge from research into practice.[69] In addition, as pointed out by Senkubuge and Mayosi in the 2013 edition of the *SAHR*, there is "no nationally agreed-upon framework for the translation of research evidence into policy, programme and practice".[70] The National Health Research Council has signalled its intention to establish a National Health Research Observatory in South Africa which will function as an information and translation system that will integrate health information from the country's multiple research platforms, co-ordinate research processes, and serve to monitor, evaluate and support translation of essential health research; however there is no clear timetable for this process.[71]

One of the challenges facing publications such as the *SAHR* is how to provide evidence of impact, given the tendency to focus on the impact of the 'research' on policy rather than on the policy debate.[72] Encouragingly, there is also a move towards understanding the 'impact of research' to encompass how polices have both changed and influenced 'new ways of thinking'. Over the past five years, there have been 29 133 hits on the *SAHR* page on Health Systems Trust's website,[a] implying that the contents of the *SAHR* are being used to generate new ideas and approaches to challenges. Each year, approximately 1 500 hard-copies of the publication are printed and widely distributed to national, provincial and district management teams. It would be wishful thinking to imply that the entire body of *SAHR* recommendations filter into policy (and as pointed out earlier in this chapter, there are a number of important areas around leadership and governance, human resources planning and management of the district health system, where analyses and recommendations in the *SAHR* have not made an appreciable difference). However, the information contained in the *SAHR* has had both instrumental (where research is translated into usable forms) and conceptual (research that changes thinking but not necessarily action) value.[73]

Despite the absence of irrefutable evidence that there is a direct causal link between the recommendations of the *SAHR* and policy changes, there is some evidence to suggest that the various recommendations made in the approximately 20 chapters of each edition of the *SAHR* have percolated into the policy-making discourse and influenced discussions around policy.

Conclusion

Three factors have contributed to the successful production of the *South African Health Review* over the years:

➤ The role of funders who chose to support the need to document the successes and challenges of the health system rather than divert their funds to programmatic and service-delivery ventures. In particular, the support of the Henry J. Kaiser Family Foundation, The United Kingdom Department for International Development, The Atlantic Philanthropies, the Swedish International Development Cooperation Agency through the AIDS Foundation, and the South African National Department of Health, is acknowledged.

➤ There have been generous contributions from the broader public health community in South Africa. Over the past 20 editions, there have been more than 850 contributors to chapters, including those working in the formal public health sector, parastatal organisations, scientific councils, non-governmental organisations, academia, and bilateral and multilateral support agencies. In a spirit of collegiality and knowledge-sharing, they have contributed in the form of chapter submissions, peer review of chapters and the provision of oversight, and support as members of the Editorial Advisory Committee.

➤ The determination and foresight of the original developers of the *SAHR*, as well as the many editors and members of Health Systems Trust who have served the publication with distinction, and have established its standards of excellence.

This chapter is dedicated to all of their inputs.

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