

A Perspective on Primary Health Care in South Africa

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Abstract

Throughout much of the twentieth century, South Africa was a global leader in the conceptualisation and development of the Primary Health Care approach. Its seminal contributions include: the Pholela Health Centre model; the pioneering health system policies of the Gluckman Commission; development of the community-oriented primary care movement; the apartheid-era emigration of South Africa's leading community-oriented primary care proponents and subsequent dispersion and development of community-oriented primary care / Primary Health Care principles internationally; the development of the progressive Primary Health Care movement; and experimentation with new models of health service delivery and primary care. These achievements remained fragmented and of limited impact as a result of hostile state interventions and an egregious policy environment prior to and throughout the apartheid era. Despite over a decade of structural reform and genuine commitment to achieving 'Health for All', a series of obstacles continues to limit the full implementation of Primary Health Care today. These include: the HIV and AIDS pandemic; health worker shortages and inequities in resource distribution; shortcomings of political, public sector and medical / health leadership; and a complex and protracted health transition. While there is strong justification for a renewed commitment to, and major investment in Primary Health Care today, this effort must go beyond addressing these persisting challenges, and more broadly incorporate innovative health system designs and experimental work at scale, in order to reorient today's over-bureaucratised and often rigid primary care system.

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Introduction

In 1994, mainstreaming Primary Health Care (PHC) in South Africa was an idea 'whose time had come'. A popular government, with an overwhelming mandate to address those marginalised by apartheid would, it seemed, be capable of introducing a model, people-oriented health care system, one that could fulfil the aspirations of the founders of the democratic South African state. Almost immediately after the installation of Nelson Mandela as the country's president, primary care available at public sector clinics throughout South Africa was declared 'free' at the point of delivery. Reinforcing such far-reaching health policy was the complementary educational policy to provide each school-going child with a nutritious food ration during the school day. Such measures were emblematic of the new government's intentions, and signalled a dramatic shift from the old regime that would surely overcome any lack of managerial or leadership experience.

Fourteen years later, and 30 years after the historic Alma Ata conference, the promise of PHC in South Africa remains largely unfulfilled. In order to understand its current state and appreciate the existing obstacles to achieving 'Health for All', it is necessary to review and critically analyse the historical development of PHC in South Africa.

Primary Health Care: South African origins, 1940–1970

Although often identified with its climactic unveiling and international adoption at the Alma Ata conference in 1978, the PHC approach traces its origins, at least partially, to a small health unit situated in rural KwaZulu-Natal, South Africa in the early 1940s. The Pholela Health Centre model, a forerunner to community-oriented primary care (COPC), was among the earliest demonstration efforts to inform and define the practice of PHC.^a

Dr Sidney Kark was appointed to head the first state-sponsored health unit to be located in a rural Bantustan, or so called 'ethnic homeland'. The unit, intended to provide comprehensive preventive and curative services, was to serve as a model upon which other health centres, both rural and urban, would be developed. Initiated by Dr Eustace Cluver, South African Secretary of Health and Dr Harry Gear, Deputy Chief Health Officer, the health centres were envisioned as a

means of establishing more appropriate health care services in the largely disregarded ethnic homelands.¹ Joined by his wife, Dr Emily Kark, Edward Jali, a medical aid graduate from Fort Hare University, and Amelia Jali, a graduate nurse from the McCord Zulu Hospital, Dr Kark established the Pholela Health Centre in rural Natal in April 1940.

From the outset, the strategy and structure of the Pholela Health Centre were profoundly innovative for their time. Integrating curative care and preventive health services in a comprehensive community-based package, Pholela utilised population-based investigations to inform the provision of health services and incorporated health education and health promotion as essential elements of the health delivery system.¹ Emphasising the provision of holistic health care, rather than simply medical care, Pholela provided one of the first working models of COPC in practice.

Unique in its focus on the health of families and the community, rather than individual health alone, the Pholela Health Centre sought to identify and address the social conditions and determinants that influence population health broadly, targeting hygiene and sanitation, nutrition, water, housing conditions and occupational threats. Specialised programmes and interventions to address the health needs of vulnerable and high risk groups, particularly women and children, were further incorporated into the localised package of health services, including: mandatory immunisations; school-feeding schemes; the establishment of household and community food gardens; child growth monitoring, breastfeeding and baby food supplementation; communal childcare services; and family planning.

A pioneering feature of the Pholela model was its reliance on social and epidemiological investigation of the local population (or 'defined community') to inform the provision of services. Dr Kark rightly argued that a detailed evidence base and empirical understanding of the community health profile (a 'community diagnosis') must be established in order to assess the appropriateness of care and adapt local health services to meet the specific needs of the population.² Through regular extension of the enumerated population and continual updating of individual and household records, the Pholela model also allowed for the measurement of changes over time and provided a longitudinal understanding of health and disease changes in the population, a defining feature of COPC.³

A key contribution of the Pholela model was its unique emphasis on community empowerment and participation in the delivery of health care. Community members and local

^a Although not discussed here, the Valley Trust Health & Nutrition Programme, originating in the 1950s and sited in the Valley of a Thousand Hills near Durban, has proved durable and influential as a community-based health, nutrition and development initiative. The programme maintains long-standing links with the University of KwaZulu-Natal.

authorities were directly involved in programme planning and health service decision-making. Distinctly innovative in its time, the health centre recruited and trained local individuals as health assistants and community educators, to extend the capacity of the well-trained health centre staff and facilitate the provision of health education, promotion and skills development at the village and at household level. All health workers at Pholela were required to understand and appreciate local conceptions of health and disease, in order to guarantee that the health centre's services and care were socially appropriate, acceptable and effective.

Empowerment of the family to improve collective health was a particularly novel feature. Health centre staff periodically met with all members of a family to complete 'family health reviews', a discussion of each individual member's health history and condition in relation to circumstances in their household and the community. Available individual, household and community-level interventions were then identified and incorporated in a unique 'family plan for health care'. Although time and labour intensive, and arguably unsustainable at scale, these efforts were emblematic of a revolutionary health system genuinely committed to providing comprehensive 'care according to need'. Pholela, thus, provided the national Department of Health (NDoH) with a working model of this comprehensive PHC-oriented health systems approach.

The value of the Pholela Health Centre approach was evident and Dr Kark was appointed technical advisor to the newly established National Health Services Commission in 1942. The Commission, led by Dr Henry Gluckman, was tasked with advising on the establishment of a National Health Service capable of providing adequate health services to all sections of the South African population, a profound step for its time.⁴

The Gluckman Report was released in 1944 concurrent with the implementation of the Beveridge Report, founding of the National Health Service in the United Kingdom (UK), and the Bore Commission which addressed a comprehensive health system for India. Gluckman envisaged a countrywide National Health Service funded through taxation and available to *"all sections of the people of this country according to their needs and not according to their means"*.^{5,6} The envisaged national health system would be based on a network of PHC centres adapted from the Pholela model. The Commission's ambitious recommendations for the reorganisation of the country's health system thus sought to establish a comprehensive health service, with the health centre serving as the primary unit in the delivery of integrated health care.

With the motivated leadership of Dr Gluckman, appointed Minister of Health in the cabinet of Jan Smuts in 1946, and Dr George Gale, the Chief Health Officer of the Department of Health (DoH), implementation of the National Health Centre Programme was fast-tracked.

In an effort to provide the multidisciplinary community-based training and research platform necessary to support the development of the planned health centres, the Institute for Family and Community Health (IFCH) was established in Durban in 1946, and was later attached to the Natal University Medical School as a teaching unit.⁷ Beyond the backing of the DoH, the IFCH enjoyed major financial support from the Rockefeller Foundation, which contributed significantly to the expansion of the health centre training and practice network across the country as well as the establishment of 44 affiliated health centres throughout South Africa by 1949.⁴

The emerging COPC approach sought to overcome two long-standing fault-lines: the delivery of clinical care distinct from measures of community health impact; and the separation of clinical practice from development-oriented approaches to health. South Africa, it seemed, was on the verge of establishing a COPC-based national health system, a pioneering achievement in health care globally.

The envisaged National Health Service however, required drastic reforms and a higher tax burden on the dominant White population, both of which exceeded the public temperament and political will of the times. As a result, the National Health Centre Programme faced considerable and increasing opposition from its inception and despite Dr Gluckman, Dr Gale and Dr Kark's committed and sustained efforts, was never properly funded.⁸

The brief ascendancy and promise of progressive liberal policy ended with the defeat of the United Party in 1948. The accession to power of the National Party, and rise of segregationist apartheid rhetoric and policies saw the remaining political proponents of health system reform removed from office and with it, the rapid decline of financial support for the National Health Centre Programme.⁸

As political and financial pressure from the State mounted, expected allies proved ineffectual and even obstructive. Preoccupied with establishing a private health sector base in South Africa, the medical profession offered little support.

The nursing profession, led by Charlotte Searle, perceived an inherent threat to the status of nurses in the Pholela / COPC approach and fervently opposed its implementation. Even the Rockefeller Foundation, distressed by the lack of political and financial support for

the IFCH within South Africa and concerned with the fascist-leaning of the new government, declined further appeals for funding.^b

Struggling in vain for nearly a decade against the reactionary government and entrenched elements of the medical establishment, so as to keep the COPC approach alive, its most ardent supporters and practitioners eventually saw no alternative but to leave the country. With the emigration of its leading proponents, the COPC movement in South Africa in effect collapsed by 1960. Without funding for its programmes or personnel, the IFCH simply dissolved. Each of the 44 health centres that had been established were abruptly closed or converted to provincial outpatient clinics, many without warning or consultation with the local community. The extensive cadre of PHC doctors, nurses and community health workers trained through the IFCH and Pholela had little option but to take up alternative clinical, teaching and academic posts throughout the country and abroad.¹

Ultimately, the progress South Africa had made over 20 years of innovative, community-based research, training and health systems development was lost. Health care and systems development in South Africa in the coming decades would focus on hospitals and an exclusivist private sector, with disastrous effect for the health of the country's citizenry.

Remarkably, the wide-spread emigration of South Africa's PHC leadership, forced by the apartheid regime, ultimately advanced the spread and development of COPC in a range of other settings and across successive generations, as tabulated in Box 1: Israel (Kark, Epstein, Cohn, Gitlin, Hopp, Abramson, Pridan), United States of America (USA) (Kark, Cassel, Cohn, Susser, Phillips, Salber), Uganda (Gale, Bennett, Letlhaku), Tanzania (Bennett), Kenya (Bennett), Iran (Cohn), Malaysia (Gale) and Thailand (Gale).^c Although profound and far-reaching, we may never realise the full extent to which the dispersion of South Africa's founding COPC proponents progressed the realisation of its ideals internationally.

In time, the Pholela model of COPC was recognised, along with pioneering efforts in China (by CC Chen), Khanna (by John Wyon), Narangwal (by Carl Taylor) and several others, as a forerunner to the modern conceptualisation of PHC, which is celebrating its 30th anniversary in 2008.

^b Personal communication between Dr I Gordon, Dean of the Faculty of Medicine at the University of Natal, and Dr R Morrison, Director of Medical & Biological Sciences at Rockefeller Foundation (23 November 1960). Papers obtained per courtesy of Dr D Yach.

^c Authors' note: this listing could well be incomplete.

Progressive Primary Health Care: An apartheid legacy, 1970-1994

During the apartheid era, two developments proved particularly damaging to the country's health care and systems development: the racial fragmentation of health services; and the deregulation of the health sector. Although undoubtedly the darkest period in the nation's history, the apartheid era also witnessed the rekindling of COPC principles in a variety of grass-roots initiatives. The enthusiastic endorsement of PHC as the means to achieving 'Health for All' by the international community, and ultimately the development and adoption of a progressive PHC philosophy by the anti-apartheid movement.

The apartheid government, in seeking to fully segregate all aspects of South African society, developed the Bantustans, or so-called 'ethnic homelands', to which Africans were involuntarily designated citizenship. Established as semi-autonomous administrative entities, each of the homelands was charged with the provision of health and other public services. Poorly organised, inefficient and often ineffectively managed, many of the homeland health services struggled to provide adequate medical and public health care. Such comment, however, should not detract from the many committed practitioners who endeavoured to improve the health and living conditions of homeland communities.

Both prior to and during apartheid, the Church made a significant contribution to health care in South Africa. British, Dutch, German, American, Swedish, Swiss and other missionary health services attempted to fill the rural and peri-urban health care gap, establishing networks of hospitals and clinic systems throughout the country to meet the needs of under-served areas.¹ Although an important contribution in providing a foundation for the homeland health system, the missionary health services were not able to meet the overwhelming demand for health care in these neglected areas. This said, mission hospital centres such as Elim and Gelukspan in the Transvaal, Cecilia Makiwane in the Cape, Charles Johnson, Manguzi and Bethesda Hospitals in Natal, and several others, proved highly competent in building hospital communities that were able to attract and retain staff. These centres formed the seed-bed for community-based health and development initiatives. An example of such a centre, pioneered in the 1970s by Erika Sutter of Elim Hospital, was the 'care-group' movement, involving hundreds and later thousands of volunteer village women. First targeting the widely prevalent and highly communicable eye condition of trachoma, efforts spread to infectious disease and, more broadly, issues of nutrition, income generation, etc.⁹

Box 1: The international dispersion of South Africa's Primary Health Care leadership

Destination of key South African community-oriented primary care practitioners		
Sidney & Emily Kark	USA	University of North Carolina (Chapel Hill) – School of Public Health
	Israel	Hebrew University – Hadassah Medical School
Helen Cohn	Israel	
	Iran	World Health Organization (WHO)
	USA	Harvard University - School of Public Health
John Cassel	USA	University of North Carolina (Chapel Hill) – School of Public Health
Harry Phillips	USA	Harvard University - School of Public Health
	USA	University of North Carolina (Chapel Hill) – School of Public Health
Eva Salber	USA	Harvard University – School of Public Health
	USA	Duke University – Department of Family & Community Medicine
George Gale	Uganda	Makerere University – Medical School
	Malaysia	WHO
	Thailand	WHO
John & Grace Bennett	Uganda	Makerere University - Medical School
	Tanzania	
	Kenya	United Nations Children's Fund (UNICEF)
Langford Letlhaku	Uganda	Makerere University – Medical School
Miriam & Gershon Gitlin	Israel	Hebrew University – Hadassah Medical School
Charlotte Hopp	Israel	Hadassah Family & Community Health Centre
Joe Abramson	Israel	Hebrew University - Hadassah School of Public Health
Helen Pridan	Israel	Hebrew University - Hadassah School of Public Health

Source: Derived from multiple sources, including Kark and Kark, 2001.¹

The formal separation of health services for Africans in the 'homelands' preceded the further establishment of ethnic-based departments of health and separate health services for each racial group; African, Coloured, Indian and White. The proliferation of public sector services that resulted was inevitably grossly inefficient and costly. In addition, deficiencies in health personnel, facilities, equipment, funding and the racial fragmentation and politicisation of health services perpetuated discrimination in health care access. With differential expenditure on health services based on a self-serving racial / ethnic ideology, rather than need, existing health disparities worsened.

Facing an economic downturn, concern in the minority White population with levels of taxation, and being under significant pressure from the private sector and medical industry, the national government deregulated the health sector. Not surprisingly, the privatisation of health care led to the rapid expansion of hospital-based curative services and facilities, thereby exacerbating already severe rural/urban disparities in resource and personnel distribution, and increasing financial barriers to service access, further disadvantaging low-income groups.¹⁰ As is evident, the

quality and nature of health care available to South Africans throughout the apartheid era was largely determined by three factors: race, income and location.¹¹

Perhaps not widely realised at the time, health care worldwide was in turmoil, as most national health systems were highly fragmented and focused on the provision of costly, curative care for elite segments of the population without ensuring adequate preventive and basic health services for the majority.¹² However, in recognition of a growing health crisis, an International Conference on Primary Health Care was organised by the WHO and UNICEF at Alma Ata, in the former Union of Soviet Socialist Republics (USSR) in 1978. Attended by 134 nations and many governmental and non-governmental organisations (NGOs), the conference introduced and enthusiastically endorsed the philosophy and practice of PHC as the means to achieving universally available health care and of attaining 'Health for All'.¹³

While there is little evidence of any meaningful impact on the South African public health service at the time, the endorsement of PHC at Alma Ata was profoundly significant in highlighting the contrast of the regressive health policies

of the apartheid era, with the revolution in health care that was occurring globally. It also provided both a practical vision and way forward. Even more importantly, it emphasised the moral values associated with health care access and framed health as a universal human right.

With the killing of Steve Biko in police detention in 1977 and the torture and murder of Dr Neil Aggett in 1982, health and health care were increasingly politicised. Attempts by the police service and health authorities to cover up Biko's death resulted in serious discrediting of the South African Medical and Dental Council.^{14,15} These events also served to heighten the division between progressive and reactionary forces, the former being strongly egalitarian; and to underline the moral deficits of the apartheid state and its overwhelming lack of concern for the needs of the wider population.

In the aftermath of the 1976 Soweto uprising, many health workers were unable to safely enter the township and more than half of the doctors at the, then named, Baragwanath Hospital and its affiliated referral clinics in Soweto resigned, or requested transfers from their posts. As a result, the local primary care clinics closed and the hospital became heavily overcrowded.¹⁶ In light of this crisis, Dr Koos Beukes, the Chief Superintendent of Baragwanath Hospital, approached Dr Lucy Wagstaff and other doctors from the clinics, to initiate a clinical skills training course specifically for nurses. He had for several years wanted to better utilise the nurses to improve the provision of health care to the community through the local clinics. Six senior nurses agreed to undergo the initial training in paediatric clinical skills and, within three months, were managing the Diepkloof clinic. Both paediatric and adult nurse-clinicians were subsequently trained through this programme and a new cadre of health worker, 'PHC nurse', was established. The PHC nurse would have the training and authority to assess and diagnose patients, as well as prescribe treatment and dispense medication (responsibilities previously limited to general practitioners).¹⁶

Although a localised development at the time, the ability of the PHC nurses to manage the primary care clinics and re-establish essential health services at community level, set an important precedent and influenced the devolution of clinical training and authority in the South African health system. After some years, the South African Nursing Council recognised the course as a postgraduate diploma and several thousand 'nurse-clinicians' have since been trained. Clinical skills training was subsequently integrated into the four-year Nurse Diploma course and 'nurse-clinicians' are now recognised as essential to PHC in South Africa. Although clearly a positive development, an unanticipated consequence was to reinforce the notion of

a 'nurse-based primary care system', thus excluding other health care workers from the mainstream of primary care and perpetuating the idea that doctors in the public sector should work in hospitals while nurses provide clinic-based care. Even today, doctors' visits to clinics are not always welcomed or managed effectively.^{17,18}

Inspired by Alma Ata and in fierce opposition to apartheid and the 'homeland' health services, a range of organisations and individuals were organised in the 1980s to develop and promote a national PHC strategy for South Africa. The National Progressive Primary Health Care Network (NPPHCN) called for the implementation of 'progressive PHC' in South Africa, based on four key principles: commitment to socio-economic development; community accountability; concerned health worker practice; and comprehensive care.¹⁹

With a broad membership of activists and health professionals, the NPPHCN provided a critical platform whereby, government policies could be effectively challenged and a future national health system could be debated.²⁰ Strongly aligned with the democratic participatory ideals of the political opposition, 'progressive PHC' was thus, a uniquely South African form of PHC explicitly born of the struggle against apartheid.

Despite the severity of state control over all aspects of South African society, several disparate attempts to translate PHC into practice emerged throughout the 1970s and 1980s. These centred on the Nqutu-Charles Johnson Memorial Hospital, Alexandra Health Centre, Khayelitsha clinics, Elim Hospital, Mamre Community Health Project, and Tintswalo / Wits Health Systems Development Unit among others. Often premised on community organisation and involvement, churches and NGOs attempted to implement key elements of PHC through small-scale health and development projects at the local level. Some of these rural sub-districts provided early examples of a functioning district health system, where services in a 'health ward' were integrated with the district hospital at its core.

A further key development in community-based care was the establishment of the Lesedi Clinic in Soweto in the mid-1980s. Initiated by Ntatho Motlana, a local physician, businessman and community leader, Lesedi Clinic was the first private hospital catering specifically to the Black population.

With Dr Rina Venter as Minister of Health and Dr Coen Slabber as Director-General, the NDoH attempted to implement elements of PHC in government health policy in the late 1980s and early 1990s. However, owing to the fundamental inability of the apartheid state to accommodate the inherently egalitarian and pro-poor principles of PHC, these efforts were profoundly flawed and achieved very little.

Breaking the mould

As the apartheid regime's control eroded and the prospect of a new political dispensation became evident, the opposition movement sought to clearly enunciate its vision and policies for a new, democratic South Africa. Marked by the development of the African National Congress (ANC) National Health Plan, the few years prior to 1994 proved critical.

The National Health Plan, presented to the public in 1994, drew much of its inspiration from the country's early COPC experience and the pioneering efforts of the Gluckman Commission, the Pholela Health Centre and the IFCH. Framed by the Alma Ata Declaration, the National Health Plan was designed in close consultation with technical experts from the WHO's Division for Strengthening Health Services and UNICEF.²¹

The National Health Plan envisioned the fundamental restructuring of the national health system premised on the PHC approach. Specifically, it sought to eliminate the fragmentation and duplication of services by integrating all health services under a single Ministry of Health; to decentralise the organisation and management of health services through a well-coordinated district health system; and to make comprehensive, community-based health care accessible to all South Africans by establishing PHC centres as the foundation of the national health system.²¹

Future imperfect: Primary Health Care in post-apartheid South Africa, 1994 – onward

Immediately following the election of the Government of National Unity in 1994, a range of pro-equity policies and programmes were initiated throughout the public sector, many of which were elements of the Reconstruction and Development Programme (RDP). In addition to a dynamic building programme for PHC facilities, the RDP also introduced free maternal and child health care, which later extended to include: free PHC for all using the public health sector; infrastructural development targeting increased access to water and electrification; the comprehensive extension of social welfare grants to previously disadvantaged populations; and a national school nutrition programme.

With many motivated members of the progressive PHC movement in the new NDoH, and a relatively clear policy direction detailed in the National Health Plan, enthusiasm for the transformation of the national health system was extremely high. Translating the progressive national policies

of the new government into effective local and provincial practice, however, proved arduous. The implementation of 'developmental' policies and the management of PHC and social services, were problematic, and appeared to lack a coherent strategy. In the heat of the moment, the new government, the Ministry of Health and involved civil society stakeholders, failed to sufficiently inform or empower health workers and the citizenry before announcing the provision of these services. The subsequent inundation of clinics attested to the condition of a population increasingly reliant on the State for all basic services and necessities.

Under the direction of the NDoH, a team of officials from each of the nine newly-established provinces, drafted a detailed implementation strategy for the development of the decentralised, district-based health system. Released for public comment in 1995, the committee's report entitled 'A policy for the development of the district health system for South Africa' informed the subsequent drafting of the 'White Paper on the Transformation of the Health System', formally endorsed by Parliament in 1997.²²

The establishment of distinct administrative authorities for each racial group and 'ethnic homeland' had resulted in 14 separate health departments functioning independently in different areas of the country. As a result, the health system inherited from the apartheid regime was highly fragmented both horizontally and vertically. The system was seriously lacking in geographic coherence, with overlapping city, district and provincial health authorities and limited national scope to reconcile gaps or duplication in service provision. As a result, the major early focus of reform was, thus, on structurally integrating the health sector.

Although disbanding the individual health departments and realigning them in a unitary Ministry of Health was accomplished relatively easily, the integration of local and provincial health systems at the district level was fraught with unexpected obstacles. The employment of personnel under a single health authority proved problematic as the pace of restructuring within the health service exceeded the slower pace at which local government and provincial restructuring occurred.^{d,22} Government and public sector unions struggled to reach agreement on more uniform salary schedules and conditions of employment; these were previously highly differentiated depending on the employing body. Further confusion was created in the decentralisation of health services when many of the newly-established district health boundaries failed to correspond administratively or geographically with redefined local government boundaries. Ambiguity in the 1996 Constitution caused confusion as it charged local government with responsibility for 'primary

^d Local government elections were held for the first time in 2000.

health services' while assigning the provincial government responsibility for 'comprehensive health service provision', without defining the operational or administrative limits of these largely overlapping areas of service provision.²⁰

Efforts to decentralise and build the district-based PHC system focused heavily on the structure and organisation of local services. Reform efforts were de facto delinked from health service outputs and measures of impact, and the process of reform was increasingly bureaucratised, becoming an end in itself rather than a means to improve health system performance. Preoccupation with organisational structure and authority thus led to a loss of momentum in systems development and service delivery and ultimately, in the under-performance of PHC services in many parts of the country.

Partly in response to this under-performance, a promising partnership developed in 1996 between the NDoH and the Health Systems Trust (HST) with support from the Henry J. Kaiser Family Foundation. The Initiative for Sub-District Support (ISDS) sought to facilitate the nationwide implementation of PHC-based health system reform by supporting the development of replicable 'models' of improved health delivery in each province. Specifically targeting the most disadvantaged districts, ISDS provided comprehensive technical assistance to sub-district managers, assisted in the development of critical support systems (drug supply, planning, information systems, etc.), worked to build managerial capacity and provided oversight of local health systems development.²³ Although a key initiative, the ISDS achieved mixed results, largely owing to inadequate resources and a lack of skilled personnel, as well as insufficient expertise and commitment to PHC among its governmental partners.

Additionally, in response to the neglect and deficiencies of the apartheid era, an extraordinary number of NGOs and community-based organisations (CBOs) came into being. As a result, South African civil society had unusual potential to support the post-apartheid reconstruction and development agenda. Disappointingly, the strengths of the NGO sector were never fully harnessed, and despite the efforts of the Independent Development Trust (IDT), many NGOs and CBOs that could have effectively partnered with government could not find funding and were forced to close.²⁴

Primary Health Care in South Africa today: A critical perspective

While the Pholela experience and COPC have played a symbolic and inspirational role, their direct influence on

district and sub-district health development is slight at best. The transformation of health systems and implementation of PHC has posed an extreme challenge to every government attempting health system reform. South Africa's experience is a little different. A diverse amalgam of factors (high rates of medical migration and severe health worker shortages; deep-seated imbalance of resources and inequities in the distribution of personnel; a complex and evolving burden of disease with emerging infectious and non-communicable epidemics; a curative-oriented health service; and deficiencies in managerial capacity and health system leadership at all levels) continue to limit the achievement of PHC in South Africa today.

Health worker shortages and inequities in distribution

An assessment by the WHO in 2003 found that more than 60% of health care institutions in South Africa struggled to fill existing posts, with more than 4 000 vacancies for general practitioners and upwards of 32 000 vacancies for nurses throughout all provinces.²⁵ In the public sector, 31% of posts were unfilled nationally and an estimated 40% of posts in the Free State and 67% of posts in Mpumalanga remained vacant.²⁶ The critical shortage of trained health personnel, and the inability to fill essential posts, constitutes a key barrier to achieving the implementation and provision of district-based health services in South Africa today. Rooted in distributional inequities in the national health system, as well as the significant loss of health workers through international emigration, the problem is severe and fundamentally systemic.

In part a consequence of the apartheid legacy of 'separate development' of health services, coupled with the privatisation of health care, the unequal distribution of health workers and resources across public and private sectors endures as a seminal obstacle to health systems development and the adequate provision of services. In 1998, 53% of general practitioners, 57% of professional nurses and 76% of all specialists worked in the country's private sector, despite this sector catering to the needs of less than 20% of the population.²⁷ Today, this trend has worsened with an estimated 63% of general practitioners now working in the private sector, nearly twice as many as in the public sector.^e Similarly, the private sector now absorbs an estimated 62% of national health expenditure providing medical care to approximately seven million people, while the public sector absorbs only 38% and provides for an estimated 35 million.²⁸

^e Unpublished data from Prof J Hugo, Department of Family Medicine, University of Pretoria, 7 August 2008.

Urban / rural disparities in health worker distribution are equally severe. The largely urban provinces of Gauteng and the Western Cape average 17.9 and 25.2 doctors per 100 000 people, while the predominantly rural Limpopo and Eastern Cape provinces maintain 12.5 and 13.5 doctors per 100 000 respectively; significantly less than the national average.²⁸

Beyond the maldistribution of personnel in the health system, severe shortages in the supply of trained medical practitioners (partly due to the emigration of graduates from South Africa) has undermined the development and functioning of the decentralised health system and the full implementation of PHC services. Recent estimates are that some 30% to 50% of South African medical graduates emigrate each year.²⁹ With emigration rates of trained nurses mirroring the flight of doctors, the Democratic Nursing Association of South Africa (DENOSA), a South African nursing union, independently estimated that upwards of 300 nurses leave the country every month.³⁰ Highlighting the magnitude of loss, the UK National Health Service alone registered 6 028 South African nurses between 2000 and 2004.³¹ Partly as a result, it is estimated that only 40% of PHC facilities in South Africa employ nurses trained specifically in PHC.³²

District health centres and clinics are disproportionately affected by such health worker shortages and the rural / urban and public / private inequities in resource distribution. Health systems development and PHC service provision are, thus, undermined at the most critical point of care.

Despite the implementation of a range of initiatives to reduce health worker loss, to address disparities in distribution and provide medical capacity where it is otherwise minimal (e.g. the rural and scarce skills allowance and the introduction of mandatory community service for all doctors and health personnel), the persistence of personnel shortages and maldistribution are due, at least in part, to long-standing policy gaps.

Tough reality of HIV and AIDS

Emerging concurrent with the country's democratic transition, the HIV and AIDS pandemic contributed a wild-card to the structural transformation of the health system and implementation of PHC. Placing immense strain on all aspects of the national health system, the pandemic exploited many of the persisting deficiencies in the coalescing health services, and overwhelmed and demoralised the South African public health system including its many PHC proponents.

The ANC's 1994 National Health Plan predicted the infection of between four and seven million South Africans by the year 2000 and explicitly articulated the need for immediate prevention and control measures. It was widely acknowledged, within South Africa and internationally, that the rapid and widespread progression of the pandemic necessitated the establishment of broad-based, comprehensive and localised health services as well as the implementation of far-reaching preventive interventions.

Despite initial commitments to comprehensive and sustained action however, the health terrain became highly contested with a growing vacuum in senior governmental leadership. Initial inaction could have been due to preoccupation with the process of transformation and details of organisational reform. Throughout Nelson Mandela's presidency, HIV and AIDS were never prioritised and took backseat to an array of other issues facing the new government. Under Thabo Mbeki, however, oversight progressed to unqualified denial. Unwillingness at the highest levels of government to address HIV and AIDS effectively led to policy confusion, programming delays and seriously compromised governmental authority. This was paralleled by escalating transmission of the virus, worsening health indicators and significant declines in life expectancy.^{33,34}

Critique of the State's response should recognise the sheer magnitude of the policy and planning dilemma posed by the AIDS pandemic and acknowledge government efforts to resource implementation of the comprehensive plan against HIV and AIDS. President Mbeki's defiance and denial can also be explained, in part, as a reaction to the historic oppression of the Black population and deep antipathy to stereotyping of male sexual behaviour. Nevertheless, the protracted period of AIDS denialism highlighted a fundamental contradiction between the rhetoric of an ANC government committed to establishing a PHC-oriented health system, and its refusal to engage an emerging health crisis and provide care according to need. Ultimately, the political leadership failed to inspire hope or provide the necessary stewardship to a public sector under increasing strain.³⁵

Lack of leadership and major divisions over how to tackle the pandemic led to the emergence of a powerful grass-roots movement embodied in the Treatment Action Campaign (TAC). Under the charismatic leadership of Zackie Achmat, the TAC, in partnership with the AIDS Law Project and a range of civil society organisations, was able to effectively elicit state intervention in the health crisis. Although much of its effort focused on popular protests and civil disobedience, public education and debate on AIDS-related issues and policies and efforts to address stigma associated with HIV and AIDS, many of its pivotal accomplishments have come

through successful legal challenges against the government. By judicial mandate, the executive and public service has been forced to implement several major PHC interventions, including a nationwide mother-to-child transmission prevention programme (extending now to provision of dual therapy) and the progressive roll-out of free antiretroviral (ARV) medication through the public sector health system.

Unfortunately, initiation of the ARV programmes has been largely hospital-based. Health personnel from district systems used to be frequently recruited to staff hospital-based ARV clinics, thus depleting PHC services. Development of ARV services at community and district level has resulted primarily from the efforts of motivated individuals, NGOs and the private sector working in defiance of official policy. As such, a major opportunity to strengthen and develop PHC and district services is being missed.

A range of other community-oriented initiatives, both non-governmental and involving public-private partnerships (PPPs) attempt to confront the pandemic at scale and address gaps that the public sector could not, or would not take on. loveLife focused on the needs of young people, implementing adolescent-oriented health services in public sector clinics and establishing a network of youth centres that provide health education and HIV prevention services. These efforts occurred alongside a nationwide media campaign that is still current and includes youth-focused television and radio programmes, publications and other forms of public media promoting awareness of sexual and reproductive health and linking young people to appropriate health services. Another initiative, Soul City incorporates targeted health promotion efforts through a diverse mix of popular media, a prime-time television show, daily radio dramas, publications and advertising campaigns. In addition to its focus on HIV and AIDS, Soul City works to raise public awareness on a broad array of social and health issues in order to positively impact population knowledge, attitudes and practices.

Recently, significant shifts in government policy and rhetoric are evident, marked by massive financial investments. These efforts are highlighting many obstacles to the full achievement of a PHC-oriented national health system. However, they also offer a fundamental turning point in national policy and a critical opportunity for renewed health service leadership.

A protracted, complex health transition

Despite socio-political change, efforts to improve the provision of health services, declines in fertility and high coverage of social grants, child and adult mortality rates

have risen dramatically since the mid-1990s. Largely a consequence of HIV and AIDS, there is nevertheless strong evidence that the rise of infectious disease in South Africa has been accompanied by an emerging epidemic of non-communicable disease, including stroke and heart disease, diabetes and cancers. The decline in life expectancy over the last decade has thus occurred in the context of a protracted and complex health transition in South Africa, with the emergence of new infectious, and non-communicable diseases, occurring alongside the 'unfinished' agenda of childhood diarrhoea and malnutrition as well as high levels of violence and accidents.³⁶

The rise in chronic illness will continue to increase demand on services at both the primary care and hospital levels. Often under-staffed and poorly managed, existing chronic care services are largely unable to absorb this emerging and significant burden. Further development and adaptation of the health system, and strengthening of the local evidence base to support the provision of locally-appropriate services, will be necessary to address the changing profile of disease.

The way forward

Despite some progress over the past two decades, South Africa remains far from realising Alma Ata's aspirations of 'Health for All'. The decline in life expectancy, high levels of infant mortality and the persistence of health outcome differentials, highlight the inability of the current district health system to rectify the institutionalised legacy of inequity or to meet the emerging needs of the population. Significant disparities in the content, quality and coverage of health services remain despite over 15 years of profound structural transformation and reform.

Can PHC re-invigorate a struggling district health system? Absolutely! But how?

The accelerated roll-out of ARV therapy at the clinic level must be accompanied by strengthening of voluntary counselling and testing (VCT) services and prevention of mother-to-child transmission (PMTCT) programmes. Effectively managing the demands of the nationwide scale-up of ARV delivery will require a far more robust PHC system and committed leadership at all levels. It will also necessitate substantial investments in the recruitment, training and support of thousands of new lay counsellors and nurses to manage the demands of the roll-out on local health services and personnel. Although a significant challenge, this is achievable and initial efforts appear promising.

The coexistence of highly prevalent chronic infectious disease (HIV and AIDS and tuberculosis) and emerging

chronic non-communicable disease will necessitate a reorientation of primary care systems to more effectively manage chronic, long-term care, while maintaining and improving the capacity of acute care services. A profound challenge for any health system, this is a fundamental and necessary step to providing effective, appropriate services that can comprehensively address South Africa's health care needs. Renewed focus on the development of effective chronic care services through the district health system is critical and must prioritise not only effective clinical management and secondary prevention, but also the implementation of comprehensive prevention, health promotion and screening programmes alongside targeted efforts to prevent and control key risk factors, particularly hypertension. As reliance on multiple vertical programmes to address such issues is problematic, substantial effort will be necessary to more fully integrate vertical programmes at the level of the clinic, the family and the patient.

Recent work on health care utilisation recognises the increasing reliance of the South African population on pluralistic health care, namely the complementary use of public and private allopathic services in conjunction with the consultation of traditional healers, herbalists, *inyangas*, faith healers and prophets.³⁷ By acknowledging the distinct strengths, as well as limitations of each health system, and working to integrate these disparate health service providers more effectively, there is potential to improve service coverage and delivery and arguably achieve increasingly comprehensive care in a way that is more socially and culturally appropriate to the population.

New evidence indicates that access to public services remains problematic, particularly for the poorest and the sickest. Despite the free provision of PHC and exemptions from hospital fees for the poor, costs associated with clinic and hospital visits (specifically transport and opportunity costs) remain a serious deterrent to health system utilisation.³⁸ Efforts to more appropriately decentralise health services to the local clinic level and improve the delivery of services should be prioritised to reduce these costs and significantly improve service access and utilisation.

The persistence of international emigration, as well as the rural / urban and public / private migration of health workers, underscores the inadequacy of current policies and incentive schemes. Beyond rural and scarce skills allowances and a community service requirement, a range of additional incentives could be introduced to more effectively manage human resources for health. These include: position-upgrades and salary increases for rural and under-subscribed posts; improved non-financial incentives (i.e. study and research leave, opportunities

for specialised training, etc.); improved health insurance coverage and benefits for public sector health personnel; and increased housing subsidies in rural settings to provide for improved accommodation and living conditions. In addition, undergraduate and postgraduate health science curricula should focus more strongly on practical PHC, and targeted interventions are necessary to provide adequate orientation, training, support and mentorship to students fulfilling their community service requirement. Increased recruitment of medical students from rural areas would also be an effective strategy to improve rural retention of nurses and doctors upon completion of community service.³⁹ These efforts should be implemented alongside increased investment in the training of nurses and nurse clinicians, mid-level medical practitioners, community health workers and volunteers. Assistance from other countries has been particularly valuable in supplementing personnel-scarce rural districts and further collaboration should be sought beyond the existing agreements (with Cuba, Iran, Tunisia and Russia). Additionally, attempts to develop more stringent international and regional frameworks regulating the flow of medical personnel could be valuable in managing personnel maldistribution at all levels.

Conclusion

The challenge to provide a quality PHC system in South Africa that can begin to reverse the excessive decline in life expectancy is a great one, but not insurmountable. Much in the COPC approach remains as relevant today as it was in the 1940s and 1950s. The Pholela experience, in particular, taught us that the responsiveness and adaptability of the health system to the ever-changing conditions and demands of the population, largely determines its relevance and effectiveness. While the challenges we face today differ, they are no less critical.

In order to salvage today's over-bureaucratised and rigid primary care service, an intense effort to develop new models and approaches to PHC delivery is warranted. It will require the best minds in the health sector to refocus peripherally, developing innovative health system designs, integrated district-based health worker training initiatives, and experimental work at scale that builds on the novel efforts in health systems development currently underway in Mexico, Brazil, India, Thailand and elsewhere. Careful consideration of the skills and competencies needed in the PHC system will be critical to its success, as will renewed focus on the unique and evolving needs of the population. Pivotal to these efforts will be a working information base.

Sustained and committed leadership is now essential. While South Africa's early advances in PHC resulted from the dedicated leadership of only a few individuals, the lack of broad-based support and sustained leadership at the highest levels of the government and medical establishment limited its adoption and stifled its development. Now that the major hurdles to establishing PHC in South Africa have been largely overcome (i.e. transformation, unification of the public sector, and demarcation of district and sub-district boundaries) the Ministry of Health must provide the leadership necessary to a broad-based national discussion on the ideal model of PHC for the country. This should emphasise 'lessons learned' from the country's rich historical experience with PHC, as well as the fast-changing health needs of the population.

Most importantly, an intense new effort to develop innovative models and approaches to PHC delivery will require a resurgence of that same spirit of inventiveness and experimentation that fostered South Africa's early advances in COPC. There is strong justification for a renewed focus and major investment in PHC today. However, if these expenditures simply result in 'more of the same', public sector PHC runs the risk of being a costly investment with limited returns, where the promise of addressing poverty and its consequences remains unfulfilled.

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