Analysing the progress and fault lines of health sector transformation in South Africa

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South Africa has implemented a number of policies that focus explicitly on equity and that seek to provide redress to those most affected by previous apartheid policies. Examples include the adoption of a primary health care approach, which in itself is a social justice philosophy, and the use of a combination of legislative, policy and resource allocation levers to achieve transformation and to improve population health.

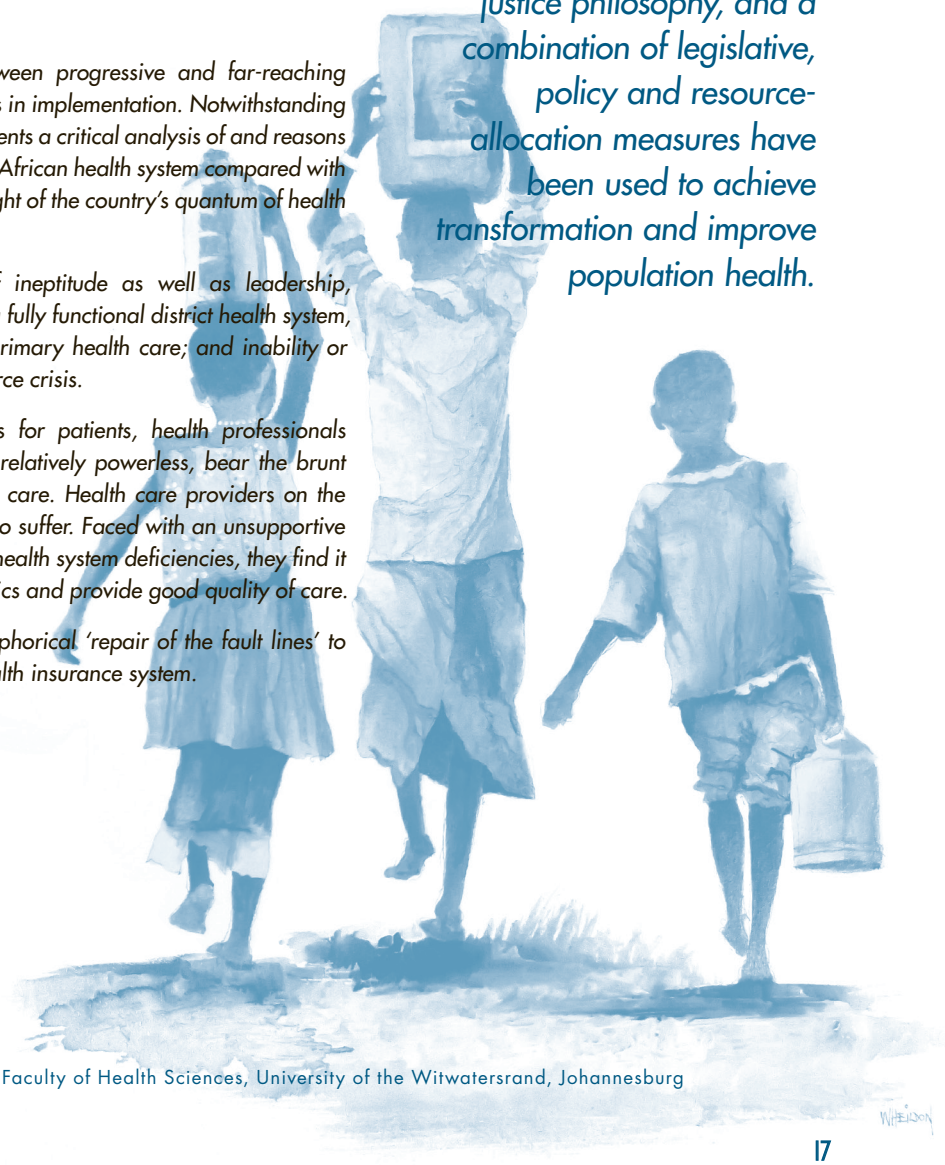
This chapter explores the disconnections between progressive and far-reaching health policies in South Africa and the fault lines in implementation. Notwithstanding the progress made since 1994, the chapter presents a critical analysis of and reasons for the relatively poor performance of the South African health system compared with other countries of similar income level, and in light of the country's quantum of health care spending.

Three fault lines are identified: tolerance of ineptitude as well as leadership, management and governance failures; lack of a fully functional district health system, which is the main vehicle for the delivery of primary health care; and inability or failure to deal decisively with the health workforce crisis.

These fault lines have negative consequences for patients, health professionals and policy implementation. Patients, who are relatively powerless, bear the brunt through negative experiences and sub-optimal care. Health care providers on the front line and at the bottom of the hierarchy also suffer. Faced with an unsupportive management environment, staff shortages and health system deficiencies, they find it difficult to uphold their professional code of ethics and provide good quality of care.

The chapter concludes with a call for the metaphorical 'repair of the fault lines' to ensure the success of the proposed national health insurance system.

A primary health care approach was adopted, which in itself is a social justice philosophy, and a combination of legislative, policy and resource-allocation measures have been used to achieve transformation and improve population health.



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Introduction

South Africa is a profoundly better place than it was before 1994,[1] with significant progress recorded in the health sector.[2] Set against the backdrop of the 1997 White Paper for the Transformation of the Health System,[3] the first wave of transformation saw the development of an enabling policy and legal framework for the complete overhaul of the health care system, the establishment of an integrated national public health system from 14 fragmented, racialised or Bantustan 'health' departments, and the removal of racial barriers in access to health care.[4] Free health care for pregnant women and children was implemented within the first 100 days of the late President Mandela's inauguration to demonstrate the new government's commitment to service delivery.

On paper, primary health care (PHC) delivered through the district health system (DHS) became the cornerstone of health care policy.[4] The 2003 National Health Act formalised the legal status of the DHS, which is the vehicle for PHC service delivery.[5] Free PHC services and the clinic-building programme played a big role in removing access barriers to basic health care. This is illustrated by an increase in visits to PHC facilities from 67 million in 1998 to 129 million by the end of March 2013,[4] and near doubling of total PHC expenditure per capita in real terms.[6]

Similar encouraging developments have been recorded in the implementation of priority health programmes, such as the expanded immunisation programme, with the country on target to be declared polio-free by 2018.[4,7] Notwithstanding the AIDS denialism that characterised the second term of democratic governance, South Africa now has around three million HIV-positive individuals on antiretroviral treatment,[4] the largest HIV treatment programme in the world. The successful programme to prevent mother-to-child HIV transmission has seen a reduction in perinatal HIV transmission rates to 2.7%, as opposed to an estimated 30% transmission rate prior to any intervention.[4]

These policies are revolutionary because of the explicit focus on equity and redress in order to benefit those most affected by previous apartheid policies. Primary health care, in itself a social justice philosophy, has been combined with legislative, policy and resource-allocation measures to achieve transformation and improve population health.

However, these policies have not been enough to turn around the overall performance of the South African health system. Although we spend 8.5% of our gross domestic product (GDP) on health care, or around R332 billion in monetary terms,[8] half is spent in the private sector catering for the socio-economic elite. The remaining 84% of the population, who carry a far greater burden of disease, depend on the under-resourced public sector.[9]

Despite South Africa's middle-income status, we have poor health outcomes compared with other middle-income countries such as Brazil with similar health spending as a percentage of GDP.[4,10] Many of the earlier gains and improvements have been compromised by an ineffective national response to the country's quadruple disease burden, which refers to four groups of health conditions: communicable diseases (especially HIV and AIDS and tuberculosis); non-communicable diseases (also called chronic diseases, e.g. high blood pressure and diabetes); maternal, neonatal and child deaths; and deaths from injuries and violence.[10,11]

Huge health and health care inequalities remain between the public and private health sectors, between urban and rural areas, among the nine provinces, and even within provinces.[4,10,12,13] Three seminal documents: the National Development Plan[13] (NDP); a 20-Year Review by the Presidency;[4] and the 2015 White Paper on the proposed National Health Insurance (NHI)[14] acknowledged that we should be doing much better.

This chapter provides an analytical perspective on the fault lines in South Africa's revolutionary health policies in praxis and their failure to realise fully both the promise and intentions of a transformative, high-performing health system. These fault lines are explored in the next section of the chapter. The concluding section makes recommendations on what needs to be done about the fault lines to ensure the success of the proposed NHI system. The chapter draws on health systems research conducted over more than two decades, with methodologies ranging from reflective diaries and ethnographic research to large-scale surveys.[15]

Fault lines in health sector transformation

There are three major fault lines in health sector transformation, shown in Box 1.

Box 1: Fault lines in health sector transformation

- Tolerance of ineptitude and leadership, management and governance failures
- Lack of a fully functional district health system, which is the main vehicle for the delivery of primary health care (PHC)
- Inability or failure to deal decisively with the health workforce crisis

Although the fault lines overlap, the following section describes them individually. Arguments are supported and are illustrated with findings from research projects.

Tolerance of ineptitude and leadership, management and governance failures

Since assuming the health ministerial portfolio, the current Minister of Health, Dr Aaron Motsoaledi has provided charismatic and energetic leadership, raising the profile of key health issues and ensuring relatively widespread support for health sector reforms among a range of stakeholders.[7] There are also many committed, competent, hard-working health service managers and health professionals contributing to change and doing an excellent job in implementing transformative health policies.[16]

However, a less-talked about problem is the crisis of ineffective management, incompetence and failure of leadership and governance at all levels of the health system, exacerbated by a general lack of accountability.[16]

In 2009, an analysis of the underlying factors behind the overspending in provincial health departments pointed to serious management flaws and leadership gaps, particularly with regard to the Health Department's core business of service delivery and the quality of such service delivery.[16] Fragmented health service planning, often unrelated to financial and human resource requirements; inadequate

health programme linkages, co-ordination and integration both within the National Health Department, and between national and provincial health departments; and 10 de facto Health Departments rather than one strong national health system, mitigated optimal performance of the health system.[16] Four years later, both the National Development Plan[13] and the 20-Year Review by the Presidency have indicated that many of these problems remain.[4]

In one of the first studies to explore corruption in the South African health sector,[17] trends in irregular expenditure (defined as expenditure incurred without complying with applicable laws and regulations), was used as one of the indirect measures of corruption.[18] Although irregular or unprocedural spending does not always result in personal gain, corruption – of necessity – involves irregular or unprocedural activities.[19]

The study found that over the four-year period from the financial year 2009/10 to 2012/13, around R24 billion of combined provincial health expenditure was classified as irregular by the Auditor-General of South Africa.[17] In the 2012/13 financial year alone, irregular spending amounted to around 6% of combined provincial health expenditure in South Africa.[17] There were also varying and erratic expenditure patterns in the nine provinces. The reality is that we do not know how much of the irregular expenditure is due to corruption, because of difficulties with direct measures or validated indicators to measure corruption. We can only postulate different scenarios: a worst-case scenario where R24 billion was lost due to corruption over a four-year period, or the best-case scenario where R24 billion was lost due to ineptitude or incompetence of public servants and inefficient management systems; the consequences of either of these scenarios are equally disastrous for the public health sector, and the people whom serves.

The study also found suboptimal audit outcomes for the nine provincial health departments, as shown in Table 1.[17,18]

Table 1: Provincial and national Department of Health audit outcomes, 2008/09–2012/13

	08/09	09/10	10/11	11/12	12/13
Western Cape	Unqualified	Unqualified	Unqualified	Unqualified	Unqualified
Eastern Cape	Adverse or disclaimer	Adverse or disclaimer	Qualified	Qualified	Qualified
Northern Cape	Adverse or disclaimer	Adverse or disclaimer	Adverse or disclaimer	Adverse or disclaimer	Qualified
KwaZulu-Natal	Qualified	Qualified	Qualified	Qualified	Qualified
Free State	Qualified	Adverse or disclaimer	Qualified	Qualified	Qualified
North West	Qualified	Unqualified	Unqualified	Qualified	Unqualified
Gauteng	Adverse or disclaimer	Adverse or disclaimer	Qualified	Qualified	Qualified
Mpumalanga	Qualified	Qualified	Qualified	Qualified	Qualified
Limpopo	Qualified	Qualified	Adverse or disclaimer	Adverse or disclaimer	Adverse or disclaimer
National Department	Qualified	Unqualified	Qualified	Unqualified	Unqualified

Key: Unqualified Qualified Adverse or disclaimer

Source: Auditor-General of South Africa, 2014.[18]

More importantly, the findings on irregular spending and audit outcomes underscore the fault lines in leadership, management and governance, namely: difficulty managing a 'federal' health system; institutional characteristics of provincial administrations (which includes the legacy of overcoming practices and the culture of Bantustan administrations); lack of enforcement of existing legislation (rather than inherent legislative short-comings); capacity constraints and different skill levels across provinces; and the inappropriate selection and appointment of officials in various provincial administrations.[17]

There are other examples of leadership and governance failures. The latter can also be seen in the failure to implement key reforms. For example, health professional education reforms are widely seen as an important strategy to improve the functioning of the health system because these reforms enhance the performance of the health workforce.[20–24] In South Africa, as elsewhere, nurses make up the majority of healthcare providers. The development of proposals to reform the education and training of nurses took more than 10 years to complete and the Regulations were eventually promulgated in 2013.[24]

Recent policy studies on these education reforms [24,25] have found ineffective governance on the part of both the South African Nursing Council and the National Department of Health (NDoH), and significant weaknesses in the policy-making and implementation capacity of these institutions.[24] Once again, the Nursing Council has postponed implementation of the new nursing qualifications framework until 2018.[25] Despite the existence of a detailed plan on nursing education, training and practice for the period 2012–2017,[26] the NDoH has established yet another task team (with external consultants) to develop proposals for nursing education and training. Hence implementation of the actual education reforms and recommendations is unlikely to happen soon.

Sadly, the Nursing Council is not the only important governance body that is in disarray – a Ministerial investigation into the effectiveness of the Health Professions Council of South Africa (HPCSA) found inter alia that there was evidence of administrative irregularities, mismanagement and poor governance.[27] The task team concluded that:

> The HPCSA is in a state of multi-system organisational dysfunction which is resulting in the failure of the organisation to deliver effectively and efficiently on its primary objects and functions in terms of the Health Professions Act 56 of 1974.[27]

The Council for Medical Schemes, a statutory body to regulate Medical Schemes in South Africa, has been without a permanent registrar (chief executive officer) for more than a year. The Registrar is responsible for the execution or implementation of the legislative mandate of the Council, and the management of all resources, including its staff. The Council provides oversight of a massive and very important industry with a total annual contribution flow of around R130 billion.[28] In light of the 2015 White Paper on NHI, the optimal functioning of the Council for Medical Schemes cannot be overemphasised.

Lack of a fully functional district health system

Although there has been progress, 22 years into democracy, we still do not have a fully functional DHS.[a] A functional DHS is expected to ensure the delivery of quality, equitable PHC services,[29] improve health outcomes for all South Africans[30] (but especially those worst off), address the social determinants of health, involve communities, and change the power relations between the centre (province) and the periphery (the district).[31]

a Much of this analysis is contained in a forthcoming chapter by L Rispel and J Moorman, entitled 'Health system decentralization in South Africa' (in *Federations and Health System Decentralization*, publication date 2016/17).

With the introduction of democracy, a large study on the development of norms needed for PHC services underscored the possibilities of changing a fragmented and racially divided health system into one based on the PHC philosophy.[32] Far-reaching recommendations were made on an essential package of PHC services, which comprised a range of comprehensive services, including women's health, mental health, and rehabilitation services, provided in an integrated fashion.[32] Quality control and continuous quality assessments were built into the proposed package, and its cost components.[32] Facility and staff requirements were closely aligned with the PHC service package. The recommendations highlighted the importance of establishing a functional DHS and managing change in the health sector.[32]

Almost 20 years later, recent studies have highlighted several constraints on achieving a fully functional DHS.[33,34] These include: policy changes on the envisaged role of local government in PHC service delivery, in part because of the lack of clarity on the meaning of municipal health services in the South African Constitution; lack of role clarity among national, provincial and local government health departments; tension and lack of trust between staff employed by provincial and local government health departments, funding and capacity problems; and ineffective and inefficient management systems.[31]

Moreover, the constitutional autonomy of provincial Health Departments creates the conditions for different interpretations of what constitutes a DHS and the structures and mechanisms that are most appropriate to ensure implementation.[16,35] The current districts are not functioning as decentralised authorities as originally intended; the head of the provincial Department of Health remains the accounting officer, and there are marked variations in financial and human resource delegations across provinces.[36] The problems are exacerbated by human resource shortages, suboptimal stewardship and leadership, and political contestations.[11,37] Formal mechanisms of accountability such as district councils and clinic or community health centre committees are either absent or not playing a meaningful role. In addition, district hospitals still function separately from and are poorly co-ordinated with PHC services in many places. Without the appropriate delegations, district health managers cannot make decisions. Hence, the perceived benefits of decentralisation, namely accountability to communities, improved health outcomes and access to quality services, have not been realised.

A further layer of complexity has been added with the centralised implementation and direct management of the pilot NHI districts[38] by the NDoH. The implementation process has challenged the authority of the provincial health departments,[7] which are responsible for policy implementation. Although the NHI pilot district implementation is accompanied by strong political stewardship, only time will tell whether these reforms will result in significant decentralisation and its intended health service benefits.

Health workforce crisis

Health workers are the personification of any health system.[39] At face value, both politicians and senior managers recognise the importance of addressing human resources for health (also known as the health workforce) to improve the performance of the country's health system.[40]

Indeed, several positive health workforce interventions, including a number of financial incentives, have been implemented since 1994.[40] The most recent and highly publicised financial incentive, which boosted health professional remuneration levels considerably, was the Occupation-specific Dispensation (OSD). However, many of the positive aspects of the OSD have been marred by implementation flaws, and evaluations of its impact have seen mixed results.[16,41,42]

In theory, we have a five-year national Human Resources for Health (HRH) Strategic Plan to address the South African health workforce crisis.[43] However, the plan lacks detail, it largely ignores lower levels of government, and the vast human resource implications NHI appear to be underestimated.[40] The critical issue of how to secure the right skills and the right numbers of health professionals at different levels of the health system is not even dealt with in the plan.[40]

More importantly, implementation of the strategies contained in the plan has been slow or non-existent, and the NDoH has missed many of its own deadlines listed in the plan. This is in part because of the extremely limited technical capacity at the NDoH, the over-reliance on costly external consultants, and organisational structures at both national and provincial health departments that are not commensurate with the size and scale of the effort required to deal with the health workforce crisis.

A critical question is whether we have a health workforce crisis in South Africa. And if so, what is the nature of the crisis?

According to the World Health Organization, South Africa has higher ratios of health professionals than its minimum norms.[39] We also have well-established training institutions (among the best in the world), highly skilled health workers, effective professional regulation, and sufficient fiscal space for relatively high remuneration levels compared with many other countries.[44]

Notwithstanding these strengths, there is a workforce crisis in South Africa that manifests in a number of different areas.

Firstly, there is a crisis of ineffective and suboptimal leadership, management and governance, which has been described earlier.

Secondly, there is a crisis of inequalities and maldistribution of health workers between urban and rural areas and between the public and private health sectors. This maldistribution between urban and rural areas is illustrated by examining the training output of professional nurses (with four years of training) across the nine provinces. In 2014, the urban areas of Gauteng and the Western Cape combined produced 1 234 professional nurses.[45] In comparison, the three rural provinces of Limpopo, North West and the Northern Cape combined produced only 501 professional nurses.[45] This urban-rural maldistribution compromises access and coverage, particularly for vulnerable populations, and is exacerbated by delays in the implementation of educational reforms.

Thirdly, there is a reported staff-shortage crisis, illustrated in that there were more than 100 000 public sector vacancies in 2010.[46] It is also demonstrated by government spending of R1.5 billion in the 2009/10 financial year on nursing agencies to hire temporary agency nurses for public sector hospitals.[47] Importantly, addressing staff shortages emerged as the most important priority among health service managers in studies conducted over the past three

years.[48,49] Because there are no national norms and standards, it is difficult to determine the extent and nature of staff shortages in the public sector and in different types of health facilities.

Furthermore, moonlighting and agency nursing among nurses, and private practice among public sector doctors, exacerbate the staff-shortage crisis. In a 2010 study, 40.7% of the 3 700 participating nurses reported moonlighting or working for an agency in the year before the study.[50] The reported health system consequences were serious, with half the participating nurses reporting that they felt too tired to work whilst on duty.[51]

Fourthly, we face a crisis of unprofessional behaviour, poor staff motivation, suboptimal performance, and unacceptable attitudes of health workers towards patients, all of which compromise quality of patient care and health service efficiency.[44] These problems are exacerbated by a general lack of accountability, reported by health service managers in several studies,[48,49] and emphasised as an issue that requires attention by the Presidency. The lack of accountability is illustrated by research on moonlighting which found that 10% of nurses took sick leave to do moonlighting when they were not sick.[51]

Lastly, South Africa faces a crisis of inadequate human resource information systems. Current information systems are fragmented and unable to inform health workforce planning and training. There are also technical problems of data quality, coverage and comparability.[16] Even where information is available, it is not used to inform decision-making.

In summary, three major fault lines explain the poor performance of the South African health system: tolerance of ineptitude and leadership, management and governance failures; lack of a fully functional district health system, which is the main vehicle for the delivery of PHC; and an inability to deal decisively with the health workforce crisis.

These fault lines coalesce to produce a number of negative consequences for patients, for health professionals, and for policy implementation. In the first instance, patients are relatively powerless and bear the brunt of these fault lines in their often negative experiences of the public health sector and the suboptimal quality of care received.[4] Similarly, health care providers on the 'front-line' and at the bottom of the health system hierarchy also suffer. Studies have illustrated that health workers find it difficult to uphold their professional Code of Ethics and to provide good quality of care in the face of an unsupportive management environment, staff shortages and health system deficiencies.[48,52] The fault lines also have negative consequences for implementation of revolutionary policies, and explain the large gap between these policies and their implementation, making it difficult to achieve the desired results.

What needs to be done?

There must be a metaphorical repair of these fault lines to ensure the success of the proposed NHI system. However, these fault lines are not inevitable – South Africa is well resourced, we have a strong foundation to build on, and there is tremendous goodwill among many stakeholders to help in making the health system function optimally. There is also considerable untapped potential among the Academy in universities, many of whom are keen to contribute to positive change.

Addressing the leadership, management and governance failures requires political will; meritocratic appointment of public service managers with the right skills, competencies, ethics and value systems; effective governance at all levels of the health system to enforce laws; appropriate management systems; and citizen involvement and advocacy to hold public officials accountable.[17]

Primary health care is at the core of revitalising and strengthening the South African health system, as enunciated once again in the 2015 White Paper on NHI.[14] However, this can only happen through a well-functioning DHS. Hence, the NDoH must develop a clear implementation plan for the establishment of a well-functioning DHS. This implementation plan should include: a clear outline of the roles and responsibilities of different levels of government; strategies for strengthening management both at district level and at all facilities within the district; a clear communication strategy to communicate the vision of PHC and of a DHS, and to ensure buy-in from various stakeholders and partners, as well as from the general public and health service users; support structures with expert capacity in each of the provinces; and clear indicators to monitor progress.[34]

This chapter has highlighted the inability or failure to deal with the health workforce crisis. An adequately skilled, productive and well-motivated health workforce is a prerequisite for universal health coverage.[53] The experience in Brazil has shown that universal health coverage reforms are more effective when careful attention is paid to health workforce challenges.[54] In South Africa, the ultimate success of the NHI will require immediate and effective action to address the critical human resource challenges facing the South African health care system.[40]

The reforms envisaged by NHI provide exciting opportunities for health system change in South Africa, rarely available in most countries. The process requires the active participation of all stakeholders, including the Academy.

The new Sustainable Development Goals[55] are a sharp reminder of 'unfinished business' with respect to the Millennium Development Goals and the unacceptable health inequalities that prevail.[55] Existing evidence suggests that a high-performing public health sector is one of the most redistributive mechanisms to reduce health inequalities.[56,57] Change in the status quo is therefore not optional, but a critical necessity.

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