Primary Health Care in SA since 1994 and Implications of the New Vision for PHC Re-engineering

2

Authors:

Tracey Naledi[i]
Peter Barron[ii]
Helen Schneider[iii]

The PHC re-engineering strategy is an essential – but not a sufficient – condition to achieve improved health outcomes; it has to be accompanied by a change of culture that incentivises system-wide planning and implementation to achieve desired outcomes and maximise strategic partnerships.

South Africa (SA) is regarded as one of the economic powerhouses of Africa and spends about 8.6% of gross domestic product (GDP) on health. However, SA does not have the health outcomes that would be expected from such investment, and some countries that spend less of their GDP on health have better health outcomes. SA's poor showing has been attributed to the rapid escalation of HIV and AIDS and tuberculosis together with a weak primary health care (PHC) system. Other health system challenges include inadequate access, coverage and quality of services; limited governance and management capacity; and limited human resources. This chapter describes development of PHC in SA from 1994 onward. The recently adopted national PHC re-engineering strategy and its implications are also discussed, particularly in terms of implications for leadership, governance and management; human resources for health; service delivery, information management and the social determinants of health. We conclude that the PHC re-engineering strategy is an essential – but not a sufficient – condition to achieve improved health outcomes; it has to be accompanied by a change of culture that incentivises system-wide planning and implementation to achieve desired outcomes and maximise strategic partnerships.

i Health Impact Assessment Directorate, Western Cape Department of Health
ii School of Public Health, University of the Witwatersrand, Johannesburg
iii School of Public Health, University of the Western Cape

Introduction

South Africa (SA) with its gross domestic product (GDP) of US$364 billion (bn) is regarded as one of the economic powerhouses of Africa. Together with Botswana, Gabon and Mauritius, it is one of four African countries ranked as an upper-middle-income economy by the World Bank.[1] In 2009-2010 estimated public and private spending on health service delivery exceeded R200bn or about 8.6% of GDP,[2] similar to the proportion spent on health in countries such as Brazil, Spain, Italy and England. However, this investment has not translated into improved health outcomes. Whereas in 1990 both SA and Brazil had an under-five mortality rate of 56 per 1 000 live births, by 2008 the rate in SA had increased to 67 per 1 000 live births while Brazil's had decreased to 22 per 1 000 live births. Even countries that spend less of their GDP on health, such as Namibia (7.6%) and Botswana (5.7%) have lower infant mortality rates.

Poor health outcomes in SA can be attributed to the rapid escalation of the dual HIV and tuberculosis (TB) epidemics. A multi-country review looking to identify over- and under-achieving countries analysed life expectancy relative to national income and HIV prevalence, found SA was under-achieving in relation to its gross national income, primarily as a result of Government's response to HIV and TB and a weakly developed primary health care (PHC) system.[3] Long-standing social determinants of ill-health resulting from the legacy of apartheid – many of which fall outside the control of the health sector – have further hampered SA's progress towards good health outcomes.

In line with the World Health Organization's (WHO) advocacy for revitalisation of PHC, and more than 30 years after its inception in the Declaration of Alma Ata in 1978, the SA Government developed a 10 Point Plan to transform the health system. Central to this transformation is the strengthening of PHC as the backbone of health service delivery. In SA the District Health System (DHS), a decentralised governance and management structure led by the District Management Teams (DMTs), is the primary vehicle for delivering PHC.

This chapter describes the development of PHC in SA post-1994 and the challenges it faces to improve health outcomes. Implications of the recently adopted national PHC re-engineering strategy are also discussed.

Key developments towards the PHC approach in SA

The PHC approach as formulated by the WHO in the Alma Ata Declaration is a philosophy governing principles and strategies for organising health systems, central to which is the notion of health as a human right, with health systems seen as the vehicle to deliver that right equitably. Health is interpreted to mean far more than the absence of disease, and is defined as a "resource for everyday life, not the objective of living", with "peace, shelter, education, food, income, a stable eco-system, sustainable resources, social justice, and equity" being prerequisites for its full attainment.[4] This definition highlights the importance of social factors in producing good health – which is not an end in itself, but key to enabling human functioning. The PHC approach is therefore more than a way of delivering health care, but rather a philosophy of attaining equitable health that governs all levels of care within the health system, and in other sectors responsible for delivering improvements in the social determinants of health.

As described in the 1995 edition of the *South African Health Review (SAHR)*, health care in SA was previously delivered in the context of a hospicentric, fragmented health system divided along racial lines.[5] Since the advent of democracy, three distinct periods in the restructuring of the healthcare system can be identified: from 1994 to 1999, characterised by post-apartheid reconstruction; 1999 to 2004, largely defined by a changing disease profile and an attendant decline in life expectancy; and from 2004 onwards, which has seen an increase in the scaling up of PHC programmes. These periods are described in more detail below.

Post-apartheid restructuring: 1994-1999

The first five years of democracy in SA (1994-1999) saw major health system restructuring. Significant changes included the amalgamation of 14 previously racially divided health departments into one national health system, removal of user fees for PHC, and removal of all fees (including at hospitals) for pregnant women and children under the age of six years in the public sector. Key policy documents, in particular the White Paper for the Transformation of the Health System in South Africa of 1997, subscribed to both the PHC approach and development of the DHS.[6] Other notable advancements were development of a PHC Package of Care, formulation of an Essential Drugs List, and publication of Standard Treatment Guidelines for PHC and hospitals.

Growing burden of disease and declining life expectancy: 1999-2004

In its second term of office the new SA Government faced a dual challenge: a health system still dealing with the legacy of apartheid, and a range of new obstacles precipitated by the growing burden of the HIV epidemic. These were accompanied by an increase in national mortality rates and a declining life expectancy index, which recorded a 10-year decline in life expectancy at birth (affecting mostly women) from 64.4 years to 54.4 years.[7,8] Total deaths increased from 381 820 in 1994 to 579 709 in 1999, with most of this increase occurring in the age range 20-50 years, and almost all of these additional deaths linked to HIV.[9] The impact of HIV on the proportion of deaths in the 'infectious and parasitic category' increased significantly,[10] and antenatal HIV prevalence grew almost fourfold, from 7.6% to 29.5% between 1994 and 2004.[11] The impact of HIV on the younger population was demonstrated in the 'Saving Children' report, which showed that 60% of all child mortality in South African hospitals between September 2003 and August 2004 was due to HIV-related illnesses.[12]

This period in the development of SA's health system also saw growing antagonism between Government and civil society, due to the former's stance on HIV and perceived reluctance to adopt internationally recognised best practices around HIV. This tension limited Government's ability to meaningfully leverage civil society to support improvements in service delivery and health outcomes, and hindered the promotion and adoption of intersectoral collaboration – a key pillar of the PHC approach. It also negatively affected the use of available resources. The then Ministry of Health's perceived lack of a vision for the health system and resultant inability to

provide stewardship for all spheres and departments of Government to address major social determinants of health further exacerbated the situation, representing a missed opportunity to strengthen the health system.

In August 2003, in the context of declining health outcomes and a beleaguered health system due to the unabated escalation in the burden of disease (BoD), Government and civil society representatives commemorated the 25th anniversary of the Alma Ata Declaration. At this forum the Kopanong Declaration was adopted, resolving to implement concrete strategies and processes with clear targets to reduce inequities in allocation of resources for PHC, with a focus on both horizontal and vertical equity. Despite the laudable objectives of the Declaration, many of these were not implemented; for example, the call to develop, implement and monitor implementation of coherent human resource (HR) plans at district, provincial and national levels was never fully realised.[13]

In 2004 the much awaited National Health Act was promulgated, using the guiding principles of the PHC approach to establish a health system in SA that recognised the importance of "decentralized management, principles of equity, efficiency, sound governance … advocacy which encourages participation … promote(s) a spirit of co-operation and shared responsibility among public and private health professionals and providers and other relevant sectors".[14] Chapter 5 of the Act made provision for legislated establishment of the DHS as the key vehicle for delivery of PHC services.[14]

Scaling up of PHC programmes: 2004-2009

The introduction of the antiretroviral (ARV) programme in 2004 provided renewed hope, the promise of increased life expectancy, and reduction in the burden on health services. It also provided a welcome morale booster for health workers, who reported taking strain from both their working conditions and the increasing numbers of patients dying from HIV-related causes without availability of an effective biomedical intervention.[15-17]

With civil society as the driving force, an intersectoral HIV and AIDS National Strategic Plan 2007-2011 was developed. Funding for dealing with HIV trebled, from R1.1bn in 2004/05 to R3.5bn in 2008/09, with overall spending for PHC increasing from R7.1bn to R12.9bn.[2] In 2006 the life expectancy for men and women started improving; in 2010 that for males reached the 1994 rate of 54.1 years, and in 2011 that for women (59.1 years) also reached the 1994 level.[2]

In 2006 the European Union funded the National Department of Health (NDoH) to establish a Partnership for the Delivery of PHC Programme, to further accelerate development of the DHS.[18] Other important policies focusing on scaling up PHC-based interventions such as publication of the Tuberculosis Strategic Plan for SA, 2007-11 were introduced, and public sector union campaigns to improve conditions of service in the health sector resulted in increased remuneration for health workers.

In April 2008 – in recognition of the 30th anniversary of Alma Ata – a conference of the National Consultative Health Forum (representing Government, the private sector, academic sphere, organised labour and civil society) issued the Birchwood Declaration on PHC, which called for a revitalised PHC strategy for SA and for a wide range of activities to be undertaken. Again, while laudable, many of the objectives of the Declaration were never fully realised; for example, the call to strengthen the role, responsibilities, authority and accountability of the DMT[19] was not fully translated into action.

An assessment of strategic challenges facing the public health system in 2008 showed several inherent systemic problems; for example, that PHC was still weak in most places in SA. It concluded that "in general, patients access the health system at inappropriate levels and by-pass the PHC clinic structure and attend hospitals for their initial contact visits and often receive primary level care at expensive tertiary institutions".[20] This sparked a series of policy reforms and public commitment on the part of Government to strengthen the health system and reduce inequities.

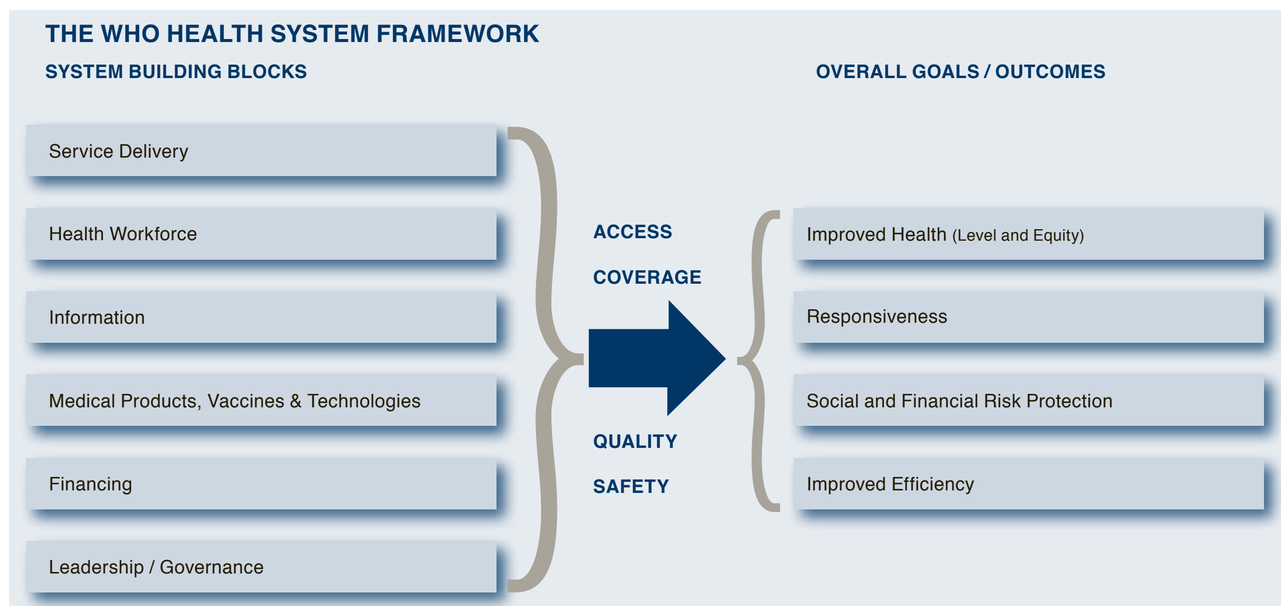
The next section deals with the roots of inadequate performance of the health system.

The roots of inadequate performance

The roots of inadequate performance in SA's health system have been the subject of a number of studies.[21-23] These reveal consensus that SA's health system provides low value for money, and that there is a large gap between good health policies and implementation of these. Despite the access and equity gains of the last 17 years the performance of PHC in SA has been poor compared with other countries, and prospects of achieving the Millennium Development Goals for health appear increasingly remote. The causes of this inefficiency have been described as systemic with both "structural" (e.g. weak DHS) and "regulatory" (e.g. lack of accountability) dimensions.[24]

The WHO framework for health systems strengthening (Figure 1) provides a useful lens through which these systemic challenges can be analysed, outlining six health system building blocks necessary to improve service access, coverage, safety and quality in order to reach the overall goals and outcomes of improved health.

Figure 1: WHO health system framework for health systems strengthening



Source: World Health Organization, 2007.[25]

Service delivery challenges: access, coverage and quality

One of the key contributors to the BoD which is likely to grow in importance in the next 20 years is non-communicable chronic diseases (NCDs). While NCDs are part of the core PHC package, they are almost universally poorly detected, managed and monitored in the health system. Existing strategies of primary, secondary and tertiary prevention appear to be failing and new approaches are required.

A significant issue related to the service delivery challenges is the gap between policy formulation and its implementation, which has resulted in inequity in service access, coverage and quality, thus hindering an effective response to SA's BoD profile.

A major challenge to improving quality of health services is poor supervision of PHC services, despite clear policy and guidelines in the form of a national 'Supervisory Manual'. For example, the 2010 *District Health Barometer* found a very wide variation in the PHC facility supervision rate between and within provinces, some districts having a rate of less than 40%.[26]

Similarly, systems for oversight and governance of clinical care are weak; many regional hospitals do not regard outreach and support for the PHC platform as part of their responsibility. However, where regional hospitals do take on this role, important successes in quality improvement have been shown. The Perinatal Problem Identification Programme which uses information on outcomes of pregnancy in respect of stillbirths and neonatal deaths is a good example of improved clinical outcomes using components of clinical governance.[27]

Structural challenges: Governance and management

Inefficiencies in the DHS have compromised SA's ability to deliver an effective PHC programme. The National Health Act mandates provincial government to pass subsidiary legislation to establish appropriate governance structures, such as district councils and clinic committees. The Eastern Cape has a draft Provincial Health Act and Western Cape has passed legislation to govern District Health Councils and is currently in the process of establishing such structures.[28] Free State and Limpopo provinces have also made significant strides towards establishing clinic committees, hospital boards and district health councils. However, in general compliance with the NHA in this regard has been weak. A consequence of this is continuation of the historical fragmentation of PHC service delivery between local and provincial governments in the metropolitan areas. In addition, many district hospitals function separately from and are poorly coordinated with PHC. Formal mechanisms of accountability via hospital boards and clinic and community health centre committees are either absent or do not play a meaningful role.

A national survey of DMTs in 2008 found that in most provinces structures were in transition.[29] Delegation of human and financial resources was inconsistent, and while managers had access to a wide range of courses for capacity development, these were not systematically aligned towards their needs. Moreover, the institutional environment often precluded innovation and implementation of new learning. Much of the decision making was still top-down from the provincial Departments of Health (DoHs). At sub-district management level provincial organograms differed considerably, most being judged as inadequate. Stronger management at sub-district level is therefore imperative, given that most district populations are larger than the WHO recommendation of 250 000 - 500 000 people, and likely to require more complex operational mechanisms.

This inadequate governance and management at district and sub-district levels has resulted in a lack of responsiveness to community needs; a general lethargy in the DHS, that neither prioritises nor takes action around pressing PHC needs; a fragmented delivery system implementing multiple uncoordinated, disease-specific interventions and campaigns from vertical programmes at provincial and national level; and problematic separation of community-, home- and facility-based functions.

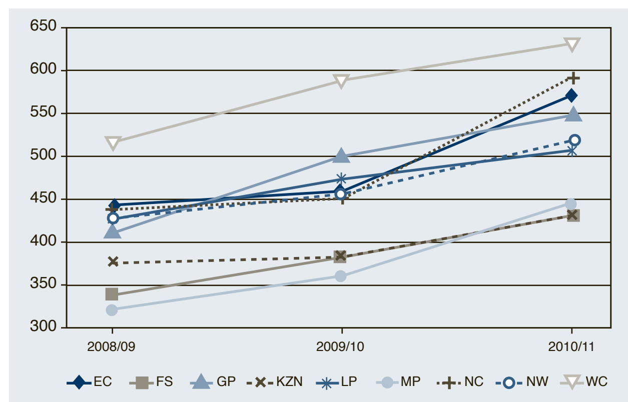
Until recently there was also a general problem of health sector stewardship, "characterised by an inversion of the natural logic for a performance oriented health system ... policy decisions are systematically decentralised, and operational decisions systematically centralized."[24]

There have been and still are a number of challenges in defining an appropriate role for the NDoH and ensuring coordination and alignment of actors towards a common purpose. This was described as far back as 1999 by Malcom Segall, who observed that "national managers convene meetings, organise training sessions, issue guidelines and propose interventions, with little or no coordination with each other and sometimes even bypassing provincial coordinators."[21] Similarly, a review of PHC implementation in 2003 reported "countless incidents where national and provincial managers are disrespectful of district managers' diaries and ad hoc meetings are called at short notice causing cascading disruption throughout the district."[20]

Resource challenges: Financial, infrastructural and human

In the 2011 SAHR Day et al. showed that there has been a substantial increase in public expenditure on PHC and the DHS between 2004/05 and 2010/11.[30] In particular they showed that expenditure for district management, services at clinics and community health care and community-based services saw real growth of 4.3%, 9.3% and 10.6% respectively, and average per capita PHC spending increased by 66% from R232 in 2005/06 to a projected rise to R386 in 2010/11 (real terms). Figure 2 shows that this trend is still increasing in all provinces.

Figure 2: Trends in per capita public PHC expenditure by province, 2008/09-2010/11



Source: Day et al., 2011.[30]

Part of this increase in funding has, however, been as a result of higher personnel costs after introduction of the Occupation Specific Dispensation (OSD). The impact of the OSD on health service quality has not yet been documented.

SA has invested significantly in the physical infrastructure of PHC, but despite this a 2003 facilities survey found major deficiencies in physical structure and security of facilities.[31] Furthermore, introduction of new services (e.g. HIV counselling and testing, ARV therapy (ART), new vaccines) and increased demands on existing services (e.g. prevention of mother-to-child transmission of HIV, and TB) exposed the inadequate infrastructural design of many facilities.[32] The report of the Integrated Support Team established to review provincial health overspending during the 2008/09 financial year also found facility and equipment maintenance to be insufficient in most provinces, which impacted negatively on service delivery and retention of staff.[20]

Challenges in human resources (HR) for health also affect provision of PHC. The HR for Health Sector Strategy, 2012/13 - 2016/17 reported that challenges in HR in SA include insufficient planning resulting in negative growth in clinical posts in particular, and inability to retain community services posts, maldistribution of HR, and high attrition rates, despite a doubling of public sector expenditure on personnel in the past five years mainly due to introduction of the OSD.[33] Although this report highlights many issues and shortcomings around availability and suitability of staffing levels in the health system and PHC in particular, it does not interrogate qualitative issues such as competence and orientation towards PHC sufficiently.

Although changes in training curricula have moved towards a PHC orientation, these have been gradual and health workers (especially nurses and doctors) are still not adequately prepared for the challenges of implementing PHC within an imperfect health system. As key players in the PHC system, professional nurses in particular still lack appropriate orientation and preparation. An assessment conducted in 12 nursing schools in the Eastern Cape found that only 6% of nurse educators had been trained in integrated management of childhood illness, 1% in voluntary counselling and testing, and none in current TB management strategies.[34] Although data on orientation of doctors towards the PHC approach are not available, the situation is likely to be similar. There have been some examples of medical students being trained at PHC facilities, but overall there still seems to be a disjuncture between health professionals' and managers' training on service delivery needs and health system priorities of PHC, in particular population and intersectoral approaches for impact on health outcomes.

Newly qualified nurses and other professionals require training in programmatic areas and policies, especially TB, HIV and AIDS, maternal, child and women's health and NCD. However, in-service and continuing medical education remain weak. Existing training is frequently conducted in silos along programmatic lines and fails to approach patient needs in an integrated or holistic fashion.

Pharmaceuticals, diagnostics and medical equipment

Pharmaceuticals, diagnostics and medical equipment are essential to attaining quality service delivery. Although an Essential Drugs List exists, mechanisms to ensure adherence to guidelines and pharmaco-vigilance systems are lacking. Management systems for forecasting, procurement, warehousing and distribution remain weak, resulting in frequent stock-outs. Even though national mechanisms to negotiate favourable prices for drugs exist, these have not been used efficiently. A notable exception, however, was the successful negotiation of halving the unit price for certain ARVs in the new ART tender in early December 2010.[36] Lists of essential laboratory tests for primary, secondary and tertiary levels of care have been developed by the NDoH recently, but not as yet widely implemented.

Information systems

PHC advocates a population-based approach that responds to the needs of people in a geographical area. As well as health system performance information, this requires information describing the BoD (both mortality and morbidity) and related risk factors. These data need to be available for the lowest level possible – at least at sub-district level – so that local-level interventions can be implemented appropriately.

In addition, availability and use of relevant, quality information is essential to ensure responsiveness and accountability of the health system. In April 2009 a large, multisectoral health information system (HIS) assessment was undertaken with the support of WHO/ Health Metric Network, and SA scored 49% for overall availability of HIS resources, including polices and processes, 48% for data management and 39% for information use for implementation and action.[37] These scores validated earlier studies that found challenges within HIS that include inadequate investment in health management information systems, an absence of a culture of information use at various levels of the health system and a lack of mechanisms for sharing and dissemination of local and provincial good practices on monitoring and evaluation.[18] There is also a lack of mechanisms to learn from and disseminate local and provincial best practices on monitoring and evaluation and to incorporate these into national policy.

It has been suggested that the suboptimal implementation of priority interventions resulting in poor outcomes could partly be attributed to this lack of monitoring and evaluation aimed at service improvement.[38]

Social determinants of health

Impacting on social determinants of health, such as changing social norms or behaviour (e.g. prevention programmes in schools for HIV), or creating enabling local environments (e.g. water and sanitation improvement) are essential in improving health outcomes. These 'upstream' interventions have been poorly implemented in SA and elsewhere in the world. As an example, violence and injury, which impact significantly on mortality and morbidity in SA and on the health sector as a whole, have solutions that largely lie outside the formal health sector.

Health promotion departments in provincial and local DoHs, where intersectoral action could be initiated, tend to be marginal players functioning in parallel to bigger programmes such as HIV and TB; also, they largely focus on behaviour change rather than catalysing intersectoral action. Attempts have been made at national and provincial level to develop 'clusters' where different Government departments are meant to work together towards a common purpose. However, evidence suggests that these have not been very successful.[39] At local government level, Integrated Development Planning (IDP) is also meant to facilitate intersectoral action, but to date a conducive environment to achieve this has not been provided. Health personnel have also not been sufficiently trained and orientated in understanding the role of social determinants of health on health outcomes and the advocacy role they need to play; nor do they possess the capacity to be effective advocates.

These weaknesses have meant that the South African health system is not client-oriented; is not trusted by users and communities; passively awaits the BoD rather than proactively seeking it out to prevent ill-health; and does not ensure that health is aligned to broader development goals.

Responses to PHC challenges

Despite the lack of international interest in PHC in the 1980s and 1990s, many countries (including SA) continued to make PHC an organising principle of their national health systems, albeit with differing levels of commitment and results. There is now a considerable body of evidence to suggest that the classic approach to PHC is not only feasible and sustainable, but has resulted in major health gains in many countries, most notably in Latin America and Asia[3] (see Box 1).

Box 1: PHC health gains in Brazil and Thailand

Brazil
The Brazilian Family Health Programme (FHP) assigns a team consisting of a doctor, nurse, nurse assistant and community health workers to a population of 3 500. The team is responsible for population health, as well as providing PHC services and making necessary referrals to other levels of care. The FHP is credited for significant declines in infant mortality rates over 12 years, from 49.7 per 1 000 live births in 1990 to 28.9 per 1 000 live births in 2002.[40]
Thailand
In Thailand, following a combination of general improvement in household economic well-being, pro-poor health insurance schemes and increasing universal access to PHC, under-five mortality dropped by 44% in the poorest quintile (from 40.8 to 23.0 per 1 000 live births) and by 13% in the richest quintile, not only improving general health status but also narrowing inequities.[41]

A review of PHC in the Americas by the Pan American Health Organization concluded that "successful PHC experiences have demonstrated that system-wide approaches are needed, so a renewed approach to PHC must make a stronger case for a reasoned and evidence-based approach to achieving universal, integrated, and comprehensive care".[42] Emerging experience with scaling up of comprehensive prevention, care and support for HIV and AIDS in Africa underscores the importance of rights-based community mobilisation, PHC and participation of lay workers in achieving health system goals such as increased access to quality health care.[43] The review also showed that countries with "good governance and progress in non-health sectors" had good health outcomes.

A return to a focus on societal and structural causes of ill-health through establishment of the WHO Commission on Social Determinants of Health has brought with it a willingness to re-examine and document experiences with more complex aspects of PHC, such as intersectoral collaboration and community participation.[44,45] The *WHO Health Report 2008* further recognises global failures in successful implementation of PHC, but reaffirms its continued relevance in improving health outcomes.[46] The WHO challenged countries to undertake four types of reforms to strengthen PHC and improve health outcomes:

- coverage reforms that ensure universal access to services and social health protection;
- service delivery reforms to make services responsive to health needs;
- public policy reforms that foster intersectoral action for health; and
- leadership reforms that foster inclusive, participatory, negotiation-based leadership to respond to the complexities of attaining health.

Key policy reforms – transforming the health sector

A change in leadership and a new political term (2009 - present) in SA brought with it a widely recognised reinvigoration of health sector stewardship that has sought to address the challenges to PHC outlined above. A key policy document which serves as a roadmap to consolidate Government's response to health system challenges is the 10 Point Plan (2009-2014), presented in Box 2.[47]

Box 2: Summary of the 10 Point Plan

1. Provision of strategic leadership and creation of a social compact for better health outcomes.
2. Implementation of a National Health Insurance (NHI) Plan.
3. Improving quality of health services.
4. Overhauling the health care system and improving its management.
5. Improving HR planning, development and management.
6. Revitalisation of physical infrastructure.
7. Accelerated implementation of the HIV and AIDS and Sexually Transmitted Infections National Strategic Plan 2007-11, and increased focus on TB and other communicable diseases.
8. Mass mobilisation for better health for the population.
9. Review of the drug policy.
10. Strengthening of research and development.

Source: National Department of Health, 2010.[47]

The change in leadership in 2009 ushered in a wave of key policy reforms, which demonstrates Government's drive to impact positively on health outcomes through transforming the health system. Some of the major achievements and activities during this phase of renewed leadership have resulted in the following:

- The scaling up of HIV prevention and treatment through a mass HIV counselling and testing campaign aiming to test 15 million South Africans between April 2010 and August 2011, which has been successful in reaching around 90% of the target and showed increasing trends of CD4 and viral load tests done at the National Health Laboratory Services during the same period.[47,48]
- New task-shifting guidelines and expansion and mainstreaming of ART services to the PHC platform.
- Prioritisation of improvement of service quality at all levels of care including PHC, with draft legislation establishing the Office of Health Standards Compliance circulated for public comment. This office will "be tasked with the development of standards and norms and quality management systems for the national health system; inspect and certify health establishments as compliant with prescribed norms and standards; and monitor indicators of risk as an early warning system relating to breaches of standards".[49] In parallel to this, six quality improvement priorities (Fast Track to Quality) were identified and include: safety and security; long waiting times; drug availability; nursing attitude; infection prevention and control; and values of staff.[49]
- A Green Paper on NHI legislation that will establish strengthened service delivery structures, administrative and management systems and be phased-in over a period of 14 years, aimed at ensuring universal access to "appropriate, efficient and quality health services".[50]
- Public debate about reducing private sector costs and discussions on the need to establish legislation to govern these costs.

PHC re-engineering

A major policy development which aligns with the objectives of the 10 Point Plan to "overhaul the health care system and improve its management"[47] is the PHC re-engineering strategy based on the Negotiated Service Delivery Agreement (NSDA) signed by the Minister of Health and numerous other Cabinet ministers and Provincial Members of the Executive Council.[51] The NSDA sets out a plan to achieve Government's goal of 'a long and healthy life for all'. PHC re-engineering is key to the success of the NSDA implementation process and seeks to shift the PHC system from a largely passive, curative, vertically and individually oriented system to one with a more proactive, integrated and population-based approach.

The core principles of PHC re-engineering are:

- to attain a population-orientation to health care, focused on meeting priority health needs of geographically coherent populations in a comprehensive manner, including prevention, promotion and good quality, essential care;
- to focus on health outcomes aimed at reducing mortality and morbidity from the major causes of ill-health;
- to develop integrated, efficient and well-supported PHC teams, guided by and accountable to communities;
- to establish a well-functioning DHS; and
- to pay closer attention to those factors outside of the health sector that impact on health, namely the social determinants of health ("upstream factors").[51]

Three PHC streams are envisaged:

- multi-disciplinary teams of clinically competent professionals in which doctors and nurses play a critical role;
- community, municipal ward-based multi-disciplinary health teams with nurses again playing a critical role; and
- effective implementation of national school-based PHC system led by nurses.[35]

Figure 3 shows the community-based PHC model proposed for SA. The three main types of health facilities within the district – district hospitals, community health centres and clinics – will have defined catchment populations, and norms and standards for HR allocated to each facility. Each clinic will have a PHC team consisting of facility- and community-based outreach components. The outreach teams will consist of at least a professional nurse (PN), and enrolled nurse (EN) and 4 - 6 community health care workers (CHWs), who will be responsible for 1 000 - 1 500 households (approximately 6 000 people). Doctors and PHC nurses will support the outreach teams and see the complex clinical cases.

Core members of the outreach teams would be the CHWs, whose function would be to:

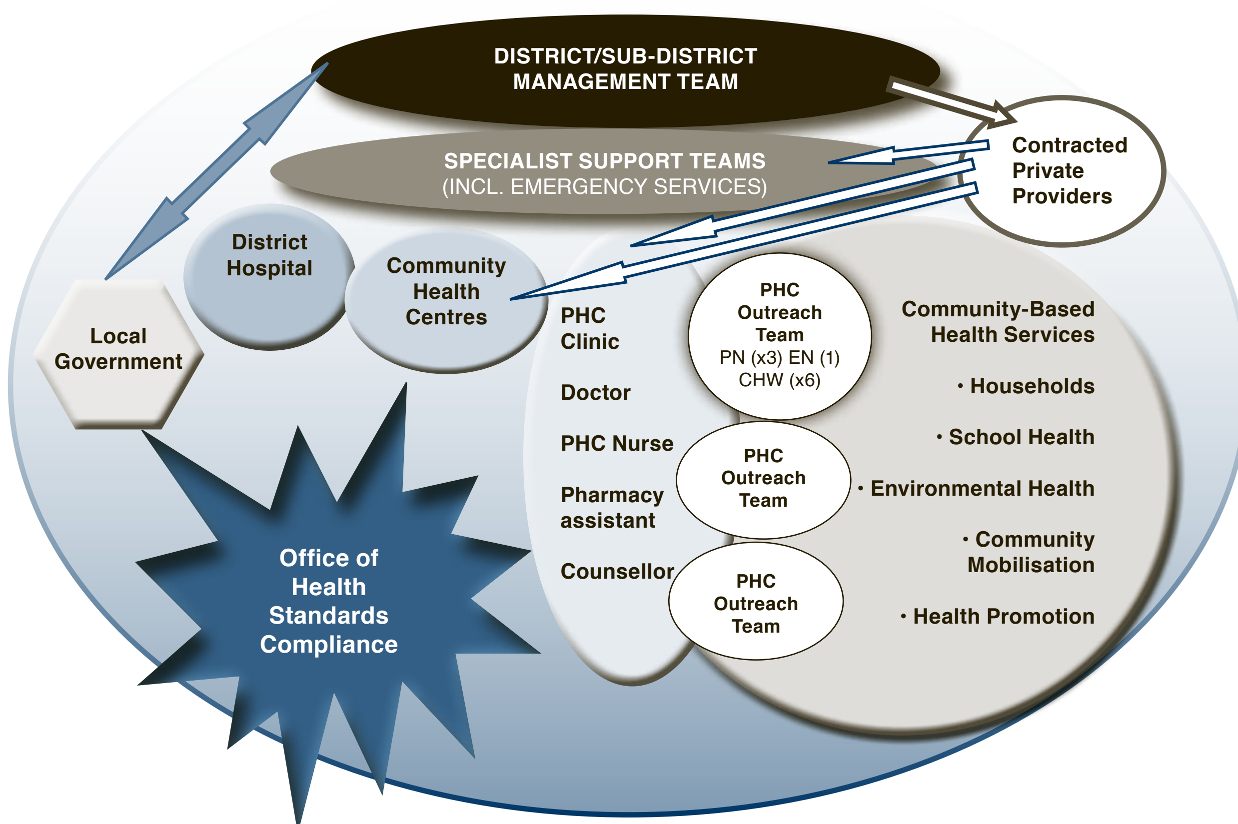
- screen, assess and refer clients to PHC facilities;
- provide information and education on key health priorities;
- provide psychosocial and adherence support;
- provide basic home treatment; and
- undertake community assessments and campaigns in collaboration with other team members.

Management capacity to improve service delivery will be strengthened by decentralising decision-making powers to DMTs and facility managers. The DMT will be responsible and accountable for everything that happens in the district. Funds for functioning of the DHS and associated PHC will be under control of the DMT, with delegated authority for budgeting and resource allocation, decisions on contracting of private providers and monitoring expenditure. The DMT will use these funds to purchase selected services from private providers (e.g. doctors, optometrists, audiologists) where these skills are not available in the public sector and where there are service gaps.

In addition to the outreach teams, other priority areas in the PHC re-engineering strategy are school health services, starting with schools in the lowest socio-economic areas and crèches; and maternal and child health specialist clinical teams in each district, responsible for clinical governance, mentorship and support to health professionals.

This new community-based approach to PHC in the PHC re-engineering strategy attempts to bring interaction between health services and users of these services closer. The outreach teams will support and facilitate a continuum of preventive, promotive, curative and rehabilitative services, from home to health facilities and back

Figure 3: Primary health care model within the district health system



Source: National Department of Health, 2010.[51]

again, through referral and follow-up. The CHWs will function as agents that bridge the gap between health facilities and clients.

The presence of outreach teams within communities, who are having conversations with communities about health and risk factors, is expected to create an enabling environment for behaviours that facilitate health, empower communities to direct local resources, and have a voice in what happens (e.g. use of legislated structures through local government can give communities a voice on the number of legal alcohol outlets).

Implications

Considering some of the WHO building blocks together with social determinants of health as a framework, implications of the new vision and strategy for PHC re-engineering are discussed.

Social determinants of health

For prevention of disease the social determinants of health must be addressed effectively. SA is currently developing national policies to increase employment, improve education quality and strengthen the functionality of local government, which is key to IDPs at local level. These upstream approaches, including improving water and sanitation provision, must be balanced with community-level, downstream approaches that seek to address social, sexual and gender norms that perpetuate the vulnerability of women and children to diseases.

The adoption of the WHO Rio Political Declaration on Social Determinants of Health on 21 October 2011 affirmed global political commitment to reducing health inequities and reaching health outcomes by addressing these determinants. Countries have been called upon to develop strategies and plans in this regard, which hopefully will provide fertile ground for SA to improve linking of the developmental agenda to health. It proposes that planning goes hand in glove with monitoring and evaluation. It is suggested that public health competencies in epidemiology that describe trends in disease burden (and associated downstream and upstream risk factors) provide evidence for required interventions for geographical areas most in need. Monitoring and evaluation of the impact of these interventions will be essential in districts.

One way of ensuring that social determinants of health are tackled holistically is to ensure coordinated intersectoral action, and the IDP process at municipal level presents an ideal opportunity for the health sector to advance the PHC agenda here. The Inter-Governmental Relations Framework Act, 2005 gives policy direction for meaningful stakeholder management for effective intersectoral action, where joint planning towards a common purpose and accountability for results can be ensured outside of a contractual relationship. The Government plans to better align local and provincial planning cycles, and together with strengthening of municipal and district management capacity this could create a conducive environment for bringing the developmental and health agenda closer at local level. The recently released National Development Plan: Vision for 2030 for SA, should also support development of an intersectoral agenda that facilitates health.

The roles of individuals, households and communities are also essential in ensuring attainment of health. People have a right to health and need a conducive environment that makes choices that facilitate health easier (e.g. regulations regarding formula feeding that make the choice of breastfeeding easier); in addition, people also have to ensure that they take responsibility for their individual well-being by making the 'right' health choices.

Leadership, governance and management

Governance and meaningful community participation in the DHS are central to PHC. To hold the DMT accountable, the governance structures need to be positioned as meaningful partners in ensuring the health of communities. In addition to having their voices heard, these structures also need to have an understanding of the social determinants of health, the health sector, acceptable and desirable norms and standards for health services, and a common vision for district development. The implications therefore are that the 'health literacy' of community members, governance structures and capacity for meaningful community engagement by the health sector would have to be improved through innovative communication methods, tools and mediums.

National and provincial senior management will have to exercise strong leadership and oversight to ensure that giving precedence to the three priority streams for PHC re-engineering, although understandable in the context of identifying immediate actions to start the process, does not divert focus from the broader health system strengthening agenda. There must be coherence in leadership and management provided by DMTs to ensure that these three priority streams are integrated with and contribute to overall improvement of quality of care and outcomes within PHC rendered through the DHS.

Provincial annual performance plans and district health plans will have to reflect the health systems strengthening component as well as the three streams, together with an agenda for local-level intersectoral action.

Information management

The management of information is essential to ensure that the DMTs distribute resources equitably within the district, prioritising areas and people who are most disadvantaged and who have the greatest need, in order to promote social justice. Thus DMTs need to be equipped to be advocates for prioritisation of geographical areas with poor health outcomes.

To do this the DMTs will require information that is geo-spatially disaggregated to identify priority areas for comprehensive interventions. To illustrate this point, experience with the BoD reduction project in the Western Cape showed that 50% of alcohol-related injury deaths occur in only five suburbs of Cape Town.[52] In the context of limited resources and capacity, such information can be a powerful tool to advocate for other Government departments and sectors to play their roles in addressing social determinants of health.

The role of public health practitioners will be essential to achieve this. HIS will therefore need to be strengthened to ensure a proactive rather than a reactive approach to addressing health outcomes. Use of technology such as mobile phones and geographical information systems needs to be explored. Service delivery information will be essential for improving quality and outcomes of health services through setting of progressive targets and monitoring their achievement.

Service delivery

The model for the DHS and that of the PHC re-engineering strategy envisages DMTs coordinating public health services with other providers and buying in services from private providers to fill service gaps. With plans to decentralise HR and financial responsibilities to these managers, their competencies will have to be improved. Provincial DoHs will have to recognise the importance and centrality of DMTs and decentralise power to them (after ensuring competence and systems capacity) in return for them assuming responsibility and accountability. The culture of planning with the purpose of achieving outcomes will have to be institutionalised, with each level of the system knowing its exact role and responsibility.

Another area where management needs to play a stronger role to improve service delivery is ensuring adequate supervision and oversight of service delivery. For example, regional hospitals should take a geographical and outcomes-based approach to service delivery and work collaboratively with district-based specialist teams and health services. Support such as referral systems to and from PHC outreach teams will also need to be strengthened.

In addition, supervision of PHC services needs to be improved. A study in Ghana showed that less than 25% of the time of health workers working in PHC (including CHWs) was spent on direct patient care. Supervision within the previous month made CHWs feel more supported, and a 31% increase in provision of direct patient care was observed when such supervision was undertaken.[53]

The relatively recent recognition of Family Medicine as a specialty by the Health Professions Council of SA and deployment of family physicians within the DHS could be an opportunity to improve clinical governance in PHC. These specialists are particularly focused on PHC and the DHS, and will need to play a strategic role in ensuring clinical governance processes are in place to spearhead quality improvement for better health outcomes.

HR for health

There are an important number of HR systems issues that will have to be carefully planned and implemented. For example, inclusion of CHWs as key members of the PHC team will require a different level of teamwork between lay and professional workers, where each knows his/her unique contribution and is recognised as an equal member of the team. The specific and shared competencies of all team members will have to be identified, maintained and systematically improved with the aim of improvement of health outcomes.

HR development directorates and units will need to understand the competency needs for PHC and align HR development plans accordingly. More broadly, HR planning and development will have to be strategically aligned to the PHC approach. SA will also need to build on experiences of task-shifting in the ARV and TB programmes and explore opportunities for further task-shifting to mid-level workers. Emergence of clinical associates and other mid-level workers, such as rehabilitation workers and counsellors, will need strengthening. This implies improved synergies between academic institutions (the producers of health workers), professional bodies that govern them, and the health services that employ them.

Conclusion

Barber et al.[54] suggest that to move from policy to successful implementation, three critical components have to be in place: small delivery units with, among others, respected leaders and 'top talent'; collection of data for setting targets and trajectories that are reviewed on a regular basis and benchmarked with internal and external peers, resulting in management decisions to improve services; and thirdly routines that would ultimately become the culture of the organisation. It is particularly this last component of establishing a new culture that permeates the South African health system that is required to support creation of a responsive health system.

Managing the process of systems level change is complex. While the PHC re-engineering strategy is essential is it not sufficient alone to achieve improved health outcomes – it must be accompanied by a change of culture that incentivises system-wide planning and implementation that achieves outcomes. System changes need to be implemented through sustained effort over time, with phasing and sequencing being central to the change strategy, so that learning by doing can occur incrementally and result in desired effects. This also requires mobilisation of strategic partners, including health workers, academic institutions, professional bodies, unions, the private sector, other Government departments, civil society and communities.

It is important to bear in mind that all of this takes time. It took Brazil over 15 years to roll out their PHC strategy systematically – now highlighted as one of the success stories of PHC internationally.

References

1 World Bank databank. South Africa country data [database on the Internet]. World Bank. [cited 10 August 2011]. URL: http://data.worldbank.org/country/south-africa.

2 Bletcher M, Day C, Dove S, Cairns R. Primary health care financing in the public sector. In: Barron P, Roma-Reardon J, editors. South African Health Review, 2008. Durban: Health Systems Trust; 2008.

3 Rohde J, Cousens S, Chopra M, Tangcharoensathien V, Black R, Bhutta ZA, et al. 30 years after Alma-Ata: Has primary health care worked in countries? The Lancet. 2008;372(9642):950-961.

4 World Health Organization. Ottawa Charter for Health Promotion. First International Conference on Health Promotion. Ottawa, Canada: 1986.

5 Van Rensburg HC, Harrison D. History of health policy. In: Harrison D, editor. South African Health Review, 1995. Durban: Health Systems Trust; 1995.

6 National Department of Health. White paper for the transformation of the health system in South Africa. Pretoria: National Department of Health; 1997.

7 Statistics South Africa. South African life tables, 1985-1994 and 1996. Pretoria: Statistics South Africa; 2000.

8 Statistics South Africa. Mid-year population estimates, 2011. Pretoria: Statistics South Africa; 2011.

9 Statistics South Africa. Mortality and causes of death in South Africa, 2008: Findings from death notification. Pretoria: Statistics South Africa; 2010.

10 Bradshaw D, Pillay-Van Wyk V, Laubscher R, Nojilana B, Groenewald P, Nannan N, et al. Cause of death statistics for South Africa: Challenges and possibilities for improvement. Cape Town: Medical Research Council: Burden of Disease Research Unit; 2010.

11 National Department of Health. National antenatal sentinel HIV and syphilis prevalence survey in South Africa, 2009. Pretoria: National Department of Health; 2010.

12 The Child PIP Group, MRC unit Maternal, Infant Health Care Strategies. Saving children: A survey of child healthcare in South Africa. Krug A, Pattinson R, editors. Cape Town: Medical Research Council; no date.

13 South African Local Government Association, Versteeg M, Hall W, May A, Maredi M, de Visser J. Position paper on the provincialisation of personal primary health care services. June 2009.

14 Republic of South Africa. National Health Act (Act 61 of 2003).

15 Thom A. Voices of a pharmacist: Ruth Ngbokota of Michael Mapongwana Day hospital in Khayelitsha, Western Cape. In: Ijumba P, Barron P, editors. South African Health Review, 2005. Durban: Health Systems Trust; 2005.

16 Cullinan K. Voice of an environmental officer: Sanjay Erra of eThekwini municipality, KwaZulu-Natal. In: Ijumba P, Barron P, editors. South African Health Review, 2005. Durban: Health Systems Trust; 2005.

17 Cullinan K. Voice of a nursing sister: Gugu Majola of Gateway clinic at St Theresa's hospital in Mount Frere, Eastern Cape. In: Ijumba P, Barron P, editors. South African Health Review, 2005. Durban: Health Systems Trust; 2005.

18 National Department of Health. Annual Report 2003/ 2004. Pretoria: National Department of Health; 2004.

19 National Consultative Health Forum. The Birchwood National Consultative Health Forum Declaration on Primary Health Care. [Internet] Gauteng: National Department of Health; 2008 [25 November 2011]. URL: http://www.doh.gov.za/show.php?id=1878.

20 Integrated Support Team. Consolidated report of the Integrated Support Team: Review of health overspending and macro-assessment of the public health system in South Africa. Pretoria: National Department of Health; 2009.

21 Segall M. Review of public health service delivery: "The bottle is half full": Policy oriented overview of the main findings. Pretoria: National Department of Health; 1999.

22 Barron P, Monticelli F. Lessons learnt in the implementation of primary health care. Experiences from health districts in South Africa. Durban: Health Systems Trust; 2003.

23 Helen S, Peter B. Achieving the Millennium Development Goals in South Africa through the revitalisation of primary health care and a strengthened district health system – position paper. 2008.

24 The National Health System: A roadmap for reform. A process convened and facilitated by the Development Bank of South Africa. Draft final report; 2008 (unpublished).

25 World Health Organization. Everybody's business. Strengthening health systems to improve health outcomes: Who's framework for action. Geneva: World Health Organization; 2007.

26 Day C, Monticelli F, Barron P, Haynes R, Smith J, Sello E, et al. District Health Barometer 2008/09. Durban: Health Systems Trust; 2010.

27 Pattinson R, editor. Saving babies 2008-2009: Seventh report on perinatal care in South Africa. Pretoria: Tshepesa Press; 2011.

28 Western Cape Provincial Parliament. Western Cape district health councils Act (no. 5 of 2010).

29 Byleveld S, Haynes R, Bhana R. District management study. A review of structures, competencies and training interventions to strengthen district management in the national health system of South Africa. Durban: Health Systems Trust; 2008.

30 Day C, Gray A, Budgell E. Health and related indicators. In: Padarath A, English R, editors. South African Health Review. Durban: Health Systems Trust; 2011.

31 Reagon G, Irlam J, Levin J. The national primary health care facilities survey 2003. Durban: Health Systems Trust; 2004.

32 van Rensburg-Bonthuyzen EJ, Engelbrecht M, Steyn F, Jacobs N, Schneider H, van Rensburg D. Resources and infrastucture for the delivery of antiretroviral therapy at primary health care facilities in the Free State province, South Africa. Sahara Journal. 2008;5(3):106-112.

33 National Department of Health. Human Resources for Health South Africa. HRH strategy for the health sector: 2012/13-2016/17. Pretoria: National Department of Health; 2011.

34 Management Sciences for Health. Equity Project Annual Report 2003. Management Sciences for Health; 2003.

35 Nursing compact. National Nursing Summit; April 2011. URL: http://www.sanc.co.za/pdf/Final%20Nursing%20Compact%20April%202011.pdf

36 Minister of Health. Massive reduction in ARV prices. [press release] Pretoria: National Department of Health; 2010. URL: http://www.doh.gov.za/show.php?id=1924.

37 Statistics South Africa. Assessment of the health information system in South Africa. Pretoria: Statistics South Africa; 2009.

38 Chopra M, Lawn JE, Sanders D, Barron P, Karim SSA, Bradshaw D, et al. Achieving the health Millennium Development Goals for South Africa: Challenges and priorities. The Lancet. 2009;374(9694):1023-1031.

39 Matzopoulos R, Myers JE, Corrigall J, Butchart A, Peden M, Naledi T. Reducing the burden of injury: An intersectoral preventive approach in needed. South African Medical Journal. 2008;98(9):703-705.

40 Macinko J, de Fatima Marinho de Souza M, Guanais FC, da Silva Simoes CC. Going to scale with community-based primary care: An analysis of the family health program and infant mortality in Brazil, 1999-2004. Social Science & Medicine. 2007;65(10):2070-2080.

41 Vapattanawong P, Hogan MC, Hanvoravongchai P, Gakidou E, Vos T, Lopez AD, et al. Reductions in child mortality levels and inequalities in Thailand: Analysis of two censuses. The Lancet. 2007;369(9564):850-855.

42 Macinko JA, Montenegro Arriagada H, Nebot C. Renewing primary health care in the Americas : A position paper of the Pan American Health Organization/World Health Organization (PAHO/WHO). Washington, D.C: Pan American Health Organization; 2007.

43 Pienaar D, Myer L, Cleary S, et al. Models of care for antiretroviral service delivery. Cape Town: University of Cape Town; 2006.

44 World Health Organization. Closing the gap in a generation : Health equity through action on the social determinants of health. Geneva: World Health Organization; 2008.

45 Gilson L, Doherty J, Lowenson R, Francis V. Challenging inequity through health systems final report knowledge network on health systems. Geneva: World Health Organization; 2007.

46 World Health Organization. The World Health Report 2008. Geneva, Switzerland: World Health Organization; 2008.

47 National Department of Health. National Strategic Plan 2010/11-2012/13. Pretoria: National Department of Health; 2010.

48 Cassim N. National Health Laboratory Services (NHLS) presentation. National Nerve Centre meeting; 28 October 2011; Pretoria, South Africa.

49 National Department of Health. Way paved for the establishment of Office of Health Standards Compliance. [press release] Pretoria: National Department of Health; 24 January 2011.
URL: http://www.doh.gov.za/show.php?id=1918.

50 Minister of Health. National Health Insurance in South Africa policy paper. Pretoria: Government Gazette No.34523; 2011.

51 National Department of Health. Re-engineering primary health care in South Africa: Discussion document. Pretoria: National Department of Health; 2010.

52 Househam KC. Presentation at 5th milestones of a global campaign for violence prevention. 5th Milestones of a Global Campaign for Violence Prevention; 6-7 September 2011; Cape Town, South Africa.

53 Frimpong JA, Helleringer S, Awoonor-Williams JK, Yeji F, Phillips JF. Does supervision improve health worker productivity? Evidence from the upper east region of Ghana. Tropical Medicine & International Health. 2011;16(10):1225-1233.

54 Barber M, Moffit A, Kihn P. Deliverology 101: A field guide for educational leaders. Thousand Oaks, Calif.: Corwin Press; 2011.