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TEN YEARS ON – HAVE WE GOT WHAT WE ORDERED?

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Introduction

In preparation for the time when democracy would come to South Africa (SA), the ANC had developed a national health plan for SA.[1] The central vision of this plan, which emphasised a focus on health and not only on medical care, was that every person has the right to achieve optimal health. The underlying philosophy for restructuring the health system was based on the primary health care approach and the goal was the creation of a single comprehensive, equitable and integrated national health system. Decentralisation was central to the plan, with a vision that responsibility for, and control over, funds would be given to the lowest possible level compatible with the maintenance of good quality care. This overview chapter briefly explores the main achievements of our health system now that we are ten years into democracy, and how far have we succeeded in attaining our vision of high quality and equitable health care. The chapter draws from the information contained in this South African Health Review as well as from the reflections of a number of individuals.[a]

When commenting on the achievements of SA's democracy,[b] Sindiwe Magona made an analogy with an African parent who sends their child to the shop for a loaf of brown bread. That parent expects their child to return timeously with what they had been asked to buy. If the child returns a day later carrying two packets of jelly then the parent is definitely not going to be happy! Is our health service a 'loaf of brown bread' or has it turned out to be something else entirely?

Undoubtedly there have been major achievements. The establishment of a unitary public health system, with the district health system (DHS) as its backbone, and based on a primary health care approach, is in itself a remarkable feat. This has required not just putting in place the appropriate administrative arrangements but also 'selling' the idea of the DHS to health care staff.

> *"A major achievement has been integrating the various homeland departments of health with the tri-cameral departments of health into the national and 9 provincial departments of health (including changing mindsets)." Yogan Pillay*

> *"The 'selling' of the DHS concept to all stakeholders took a long time but finally it paid off. In 1997, when the DHS was introduced in KZN and other provinces, there was no understanding of the concept and worse still there was resistance to change. In 1998 - 1999, although there was some degree of understanding, this appeared to be clouded by personal agendas and protection of turf. By 2003 there was a clear understanding of the concept and serious attempts were underway towards implementing DHS." Gcina Radebe*

a This chapter includes quotes from a number of people who were invited to comment on the five major successes of the DoH in the first ten years of democracy and the five major challenges for the years ahead. These are: Nzapfurundi Chabikuli, Lucy Gilson, and Helen Schneider, Centre for Health Policy (CHP); Gcina Radebe, Sisonke District Manager; Puleng Molefakgotla, Mogale City-Krugersdorp District Manager; Yogan Pillay, Chief Director Strategic Planning, DoH; Chauke Ngoma, Director: Community Services, OR Tambo DM and Nigel Hoffman, Chief Medical Officer, Umzimkhulu Local Service Area..

b Comment on Democracy during the 7th "Time of the Writer" Festival, Durban, March 2004.

Measures to improve access to health care included introducing free care for pregnant women and for children under 6 (1994), as well as the introduction of free primary health care for every citizen (1996). These are especially significant equity oriented policy measures, in an era when the international trend is towards user fees.

The policy objective of decentralising the management of health services to the local level has encountered a number of problems arising partially from a legislative vacuum that will be resolved by the National Health Bill. There has also been a seeming reluctance from some provincial staff to devolve power. Although decentralisation remains a long term goal, in the interim, responsibility for district health services is set to remain with provinces.

"Establishing a single health delivery authority at health district level and improving intergovernmental relations among all three spheres of government has been a challenge." Yogan Pillay

One of the major challenges in implementing the primary health care approach has been strengthening the multi-sectoral vision. In many instances rural health care has been compromised by lack of infrastructure, including basic services such as roads, water and electricity. The requirement for municipalities to develop integrated development plans will hopefully assist in overcoming some of these problems and build the multi-sectoral approach.

"There are no clear policies on how intersectoral collaboration, a key requirement for PHC delivery, can be achieved. The higher echelons block attempts on the ground. The Integrated Development Plan process is one avenue that could assist in motivating and reinforcing this collaboration." Gcina Radebe

The creation of the National Drug Policy and Essential Drugs List (EDL) has been a significant initiative, widely used by all public sector and pharmaceutical services, that is making an important contribution to improved supply of and access to drugs.

"The introduction of Essential Drugs List has made the budgeting for drugs easier as it allows specific quantities of drugs to be ordered at a given period. This has improved the entire production chain ....and leads to better distribution." Chauke Ngoma and Nigel Hoffman

The creation of the District Health Information System (DHIS) represents another important building block in facilitating improved care. However the DHIS needs to be strengthened. Reports of inaccurate record keeping are widespread, and borne out by a survey of PHC facilities which found that more than a third of clinics provided discrepant or inconsistent data.[2] Greater attention is required not least in the area of supporting and encouraging facility staff to be more aware of the value of reliable and accurate data, and in providing training to better equip them in record keeping.

Monitoring Progress in the Health System

This SAHR places particularly strong emphasis on frameworks for monitoring and evaluation, in keeping with the publication's focus on evaluation of progress that has been achieved over the last 10 years. The Department of Health's 'Health Goals, Objectives and Indicators 2001-2005' together with a variety of disease- and issue-specific frameworks, and several international frameworks, provide the indicators and targets against which progress is measured, together with updated priorities identified in the DoH Strategic Plan for 2004/05-2006/07.[3]

In assessing our progress to achieving equity in access to health and health care, chapters in this Review raise a number of issues with regard to measurement of indicators. Despite progress having been achieved in both the quality and quantity of data that are now available, monitoring efforts are hampered by inappropriate or poorly developed frameworks reflecting difficulties in identifying what should be measured, or by complex data that are difficult to quantify. Alternatively data do exist but they are old or of poor quality, as is the case with some information provided by the DHIS.

There remain significant challenges in answering questions about how well the health system is performing. Broad measures of health may fail to explain the whole story, especially in light of the HIV epidemic. Population or other averages often mask important variations within sub-groups of the population. It is important that continued development of a framework for health system performance is undertaken at national and other levels. The selection and use of indicators is equally important. They need to be customised to their specific purpose and context of use, while maintaining consistency and comparability through use of uniform data definitions and data standards.

To monitor equity, comparative data need to be available by race, age, gender, urban/rural location, and socio-economic status. It is encouraging that this monitoring has been initiated by the DoH and that there are plans to include equity indicators as a part of the strategic planning process.

Legislation

Legislation has been an area of tremendous achievement. "As we reach the 10th anniversary of freedom and democracy, the range of health legislation passed since 1995 must be considered impressive, and substantial progress has clearly been made in reaching many of the goals reflected in the White Paper on Transformation and required in the Constitution."[4] The Constitution has played a significant role in providing the framework for a series of legal judgments that have entrenched the rights of South Africans to access health care.[4]

> *"Achievements include the articulation of a rights based approach to health, including a commitment to greater equity, the patients' rights charter, Batho Pele, and choice on termination of pregnancy."*
>
> *Helen Schneider, Lucy Gilson and Nzapfurundi Chabikuli*

Over the years, commentators in the Review have regretted absence of national legislation to guide the developments in the sector and clarify the responsibilities of all three spheres of government. The National Health Bill, which contains provisions that could have significant implications for equity, was eventually brought before Parliament in 2003 and is likely to be promulgated in 2004.

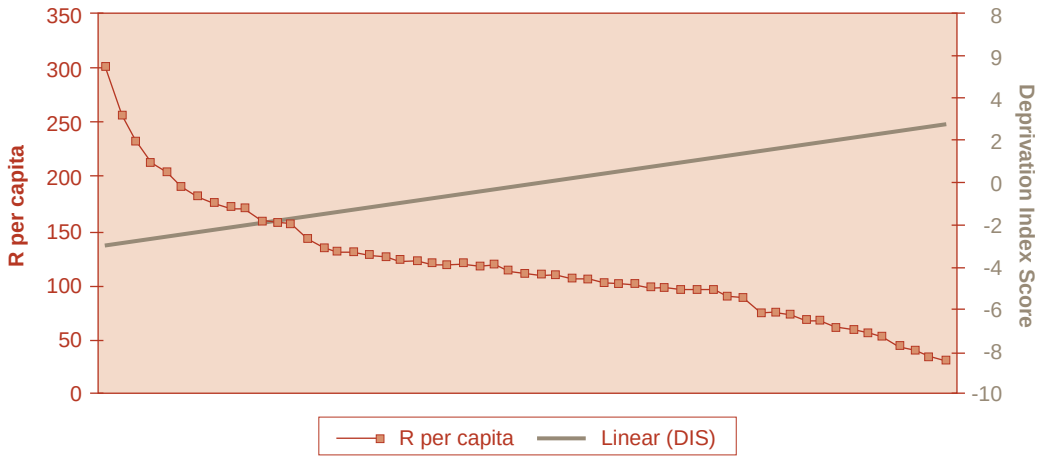
Health Financing

Although there has been an overall increase in spending in the health sector, wage increases and inflation have undermined this, as has HIV/AIDS.[5] Despite measures put in place to regulate the private sector the insured population has shrunk from just under 17% of the population in 1997 to only 15.2% of the population in 2002. The actual number of people dependant on the public sector has grown by 6.5 million people since 1995, and real per capita spending in SA as a whole has not increased substantially (Figure 1).[5]

There has been a reduction in *inter*-provincial per capita spending, but this masks *intra*-provincial inequity that is particularly worrying at primary care level, where per capita spending ranges from R389 to R42 between the highest and the lowest spending districts (Figure 2). The basic PHC package recommended by the NDoH, excluding HIV-related services, is estimated to cost around R220 meaning that most districts are simply not able to afford even this. Since primary health care is acknowledged to be the most equitable level of care, this is an area that needs to be targeted for attention, although it is recognised that many disadvantaged and under-served districts face a challenge in both seeking and absorbing increased resources.

Figure 1: Per capita expenditure (R/year, real 2003 prices)

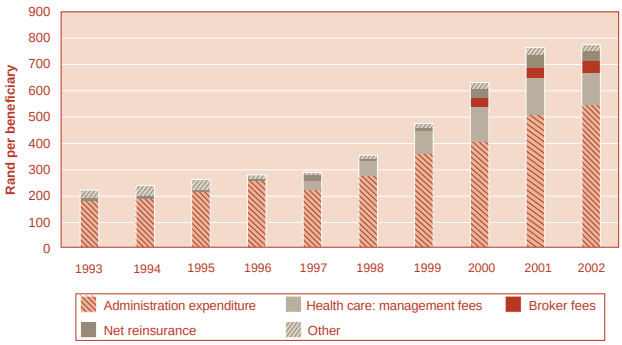
Figure 2: Financing per capita vs linear deprivation index score across health districts in SA, 2001/02



While capturing accurate costing of PHC services is improving, it remains a challenge:

> *"The cost for PHC services has been done using different formulas. Although most districts have conducted District Health Expenditure Reviews, the quality of data used leaves much to be desired. Expenditure per capita varies from facility to facility, sub-district to sub-district, and district to district. This is still a big challenge, especially in rural areas."*
> *Puleng Molefakgotla*

Figure 3: Real non-health expenditure per beneficiary (2001 prices)



The Private Sector

Control of private sector medical schemes has been implemented through the establishment of the Medical Schemes Council and various Acts of Parliament. The requirements of open enrolment and community rating have been successful in preventing direct discrimination.[6] Nonetheless rampant inflation and insufficient regulation of the supply side of the market have resulted in startling contrasts with public sector expenditure. The ratio of expenditure per capita by medical schemes to public sector provincial health spending has risen from 4.5 in 1997/98 to 7.1 in 2002/03. In this period public per capita expenditure remained little changed in real terms, and the changing ratio highlights the sharply increasing costs in the private sector. This increase in costs is making medical scheme coverage progressively more expensive, resulting in lower coverage. Much of this increase is accounted for by sharp rises in non-health expenditure (Figure 3).

The ongoing inequity between those with access to private medical care and those dependent on the public sector remains one of the biggest challenges for the South African health system.

> *"Funding is a challenge - increasing funds to the public sector, achieving greater cross-subsidy between rich and poor population groups, and preventing cost escalation, especially in the private sector."*
> *Helen Schneider, Lucy Gilson and Nzapfurundi Chabikuli*

Health has become big business, and the increasing impact of globalisation, more specifically the General Agreement on Trade in Services (GATS) being negotiated under the auspices of the World Trade Organization, in which health is classified as a service rather than a basic human right, has implications for the future shape of our health system. If we are to protect the idea of access to health care as a human right, our stance with regard to GATS will impact on what will be possible in the future. The health sector should perhaps be expecting to be extensively consulted by the Department of Trade and Industry in regard to negotiations that will impact on health care services. The Council on Higher Education has commissioned an investigation on

GATS to assist with the formulation of a South African country position on GATS with respect to higher education[7] and a similar initiative might be of assistance to the health sector.

Human Resources

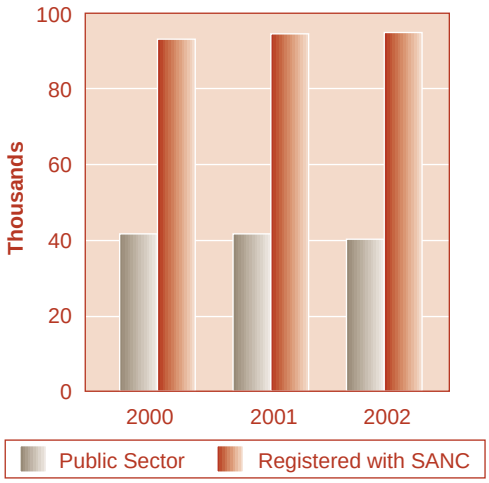
A comprehensive human resources plan has not yet been developed, however recognising the absolute centrality of health personnel, the DoH has been diligent in putting in place a number of interventions intended to strengthen the distribution and retention of personnel, especially in rural and under-served areas. Initiatives have included recruiting doctors from other countries to provide care in rural areas, Community Service for a selection of key categories of health personnel, and a rural and scarce skills allowance. Despite these attempts, ratios of public sector health personnel to the population have not improved, and for some categories of personnel appear to even be worsening. The high number of vacant posts is indicative of the challenge faced by the country in improving health personnel ratios (Table 1).[8]

Table 1: Percentage of health professional posts vacant, 2003

Province	%
Eastern Cape	28.4
Free State	40.7
Gauteng	31.9
KwaZulu-Natal	24.5
Limpopo	13.4
Mpumalanga	67.4
Northern Cape	27.3
North West	33.0
Western Cape	13.8
South Africa	31.1

There are insufficient data monitoring flows of personnel, however the literature points to increasing numbers of skilled personnel migrating abroad, and one study found that between 20 and 45% of community service personnel intend to work overseas once they have finished their training. Trends in nurse distribution illustrate that although there is an increase in the number of nurses who register with the South African Nursing Council (SANC), the actual number employed in the public sector has slightly shrunk, pointing to the likelihood that an increasing number of nurses are either moving to the private sector or abroad (Figure 4).

Figure 4: Number of professional nurses working in the public sector and number registered with SANC



Health personnel cite low levels of job satisfaction, poor working conditions, despondency in the face of the HIV epidemic, and unsatisfactory management, as well as inadequate salaries, as underlying their dissatisfaction with working in the public sector.

Efforts to improve management skills and monitor the impact of the new allowances will be essential to improved distribution and retention of health personnel. So too will be assessment of the introduction of the new category of midlevel worker within the medical profession and the commitment to increase cadres of CHWs. A further challenge will be a better understanding of recruitment strategies to select personnel likely to remain in the public sector.

"While the introduction of PMTCT has a relatively small effect on the burden of illness in the country, it has a major effect on morale of patients and health care practitioners." Chauke Ngoma and Nigel Hoffman

Health Status

The health of the nation is characterised by a quadruple burden of disease, with the impact of HIV/AIDS added to the combination of a high injury burden, conditions related to underdevelopment and chronic diseases.[9]

By 2000, the single leading cause of death was HIV/AIDS, although more people died of a combination of chronic diseases than of HIV/AIDS. However, South Africa's burden of disease is not shared equitably among the population, and pervasive social inequities that have their roots in the apartheid era, are replicated by differentials in morbidity and mortality figures among racial groups.

Table 2: Percentage of households with access to selected household facilities, 2001

	Formal housing (%)	Electricity for cooking (%)	Piped water (%)	No toilet (%)
African	55.5	39.3	80.3	16.9
Coloured	85.7	82.3	97.6	6.0
Indian/Asian	92.7	97.1	99.2	0.8
White	95.1	96.6	99.3	0.7
SA	63.8	51.4	84.5	13.6

Table 3: Infant mortality rate and life expectancy at birth, 2002

	Infant mortality rate (per 1000 live births)	Life expectancy (years)	
		Men	Women
African	67	45.8	50.4
Coloured	24	58.4	64.0
Indian/Asian	11	63.4	69.5
White	7	67.7	73.7
SA	59	49.9	55.0

Inequities are even more marked among older persons, although there are inadequate data to monitor the health of this group properly (Table 4).

Table 4: Percentage of individuals 60+ with access to selected household facilities, 2001

	Piped water (%)	Electricity for cooking (%)	Radio (%)
African	70.60	30.23	70.82
Coloured	97.95	83.83	78.06
Indian/Asian	99.12	97.23	91.38
White	99.19	95.89	94.19
SA	79.42	49.81	79.79

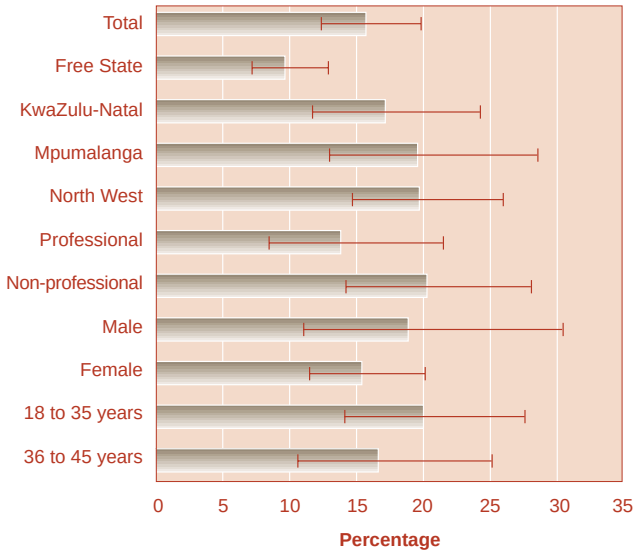
Even accounting for the impact of HIV/AIDS, the proportion of the population over 60 years in SA is expected to continue to grow, and the burden of noncommunicable diseases increase. High levels of communicable diseases combined with a large noncommunicable disease burden places a heavy demand on the health system, and caring for the ageing population will require far-reaching social and economic planning.

HIV/AIDS

HIV prevalence among public sector antenatal clinic attendees has risen from around 7% in 1994 to 27% in 2002. However prevalence appears to be levelling out, and results from HIV testing among antenatal clients less than 20 years old indicate that there may be grounds for cautious optimism that prevalence is actually declining in this age group. The higher prevalence of HIV among people living in urban informal accommodation highlights the link between deprived socio-economic conditions and increased risk of infection.[10]

The devastating impact of the epidemic has profoundly affected the health system. The care needs of patients suffering from opportunistic infections and from AIDS have placed severe strain on services, often disproportionately on some of the most disadvantaged facilities. Health workers have been at risk of becoming overwhelmed with a sense of hopelessness in the face of sickness that they, until recently, have not been able to provide any treatment for. In addition, many health workers have had to cope with being HIV positive themselves or with sickness in their own families. The overall effect has been to soak up scarce funds and increase attrition.

Figure 5: HIV prevalence among health workers, 2002



The implementation of the comprehensive plan for the prevention, treatment and care of HIV/AIDS and related illnesses[11] is at risk not least from continuing stigma. By far too few prominent people have provided leadership through publicly being tested or acknowledging the impact of the disease on friends and members of their family. The declaration by Mangosuthu Buthelezi at the funeral of his son in April 2004 may hopefully instigate greater willingness on the part of public figures to be more open.

The difficulties in implementing PMTCT, most of which have to do with generic health system weaknesses including inadequate facilities and insufficient supervision and support, as well as stigma within communities, highlight the challenges to providing effective treatment and care for those affected by the disease.

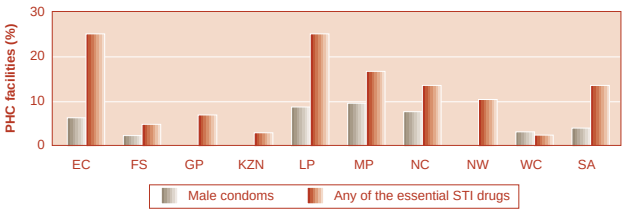
Large increases in funding for HIV/AIDS have been set aside and are intended to be sufficient to provide antiretroviral therapy (ART) to those eligible. Critical to the success of this programme will be the integration of ART services into the health system, and ensuring that this does not become a vertical programme. The estimates of additional personnel that will be needed in order to provide ART are testament to the strain this could put on a system that is already fragile. A significant challenge lies in ensuring that additional resources are used to strengthen the system as a whole, and this will be especially important in order to avoid deepening existing inequities in access to health care.

That South Africa has the seventh highest number of cases of TB in the world underscores the relationship between HIV infection and TB. HIV is the greatest individual risk factor for TB, and over half of smear positive TB patients are HIV positive.[12]

STIs

The link with HIV reinforces the importance of addressing sexually transmitted infections (STIs). Current estimates of incidence are considered to be much lower than the actual burden of disease. There is considerable variation between provinces of the annual incidence of new STI episodes. This ranges from 3.4 per 100 in the Northern Cape to 10.2 per 100 in KwaZulu-Natal.[13] However there seems to be agreement that these differences are not solely explainable by different levels of the epidemic, highlighting possible inequities in access to and or quality of care. The provincial variation in stock-outs of male condoms and essential STI drugs demonstrates a wide variation in quality of care (Figure 6).

Figure 6: Percentage of facilities with stock-outs, 2002



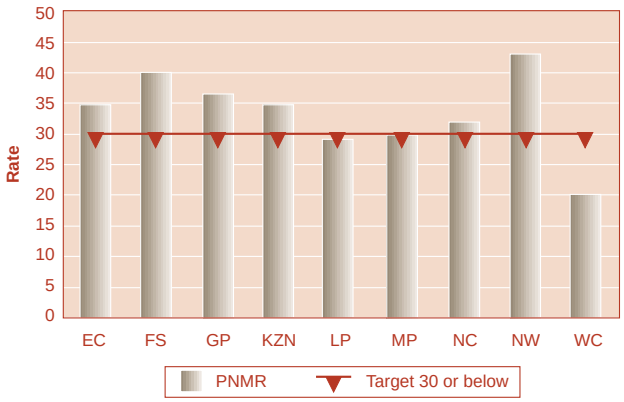
Treatment of STIs is an area of care where the private sector plays a larger than normal role with general population and points to the need for strengthening monitoring of private sector.

Women, Children and Young People's Health

".....the number of orphans is increasing rapidly and orphan care is fast becoming a major challenge, including for the health sector." Chauke Ngoma and Nigel Hoffman

Perinatal mortality rates are still above the target of 30 deaths per thousand live births in most of the nine provinces (Figure 7). Available information seems to indicate that despite the problems regarding maternal and perinatal care having been

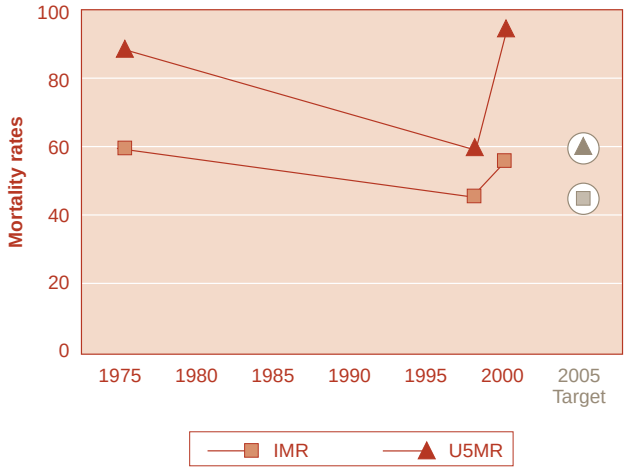
Figure 7: Perinatal mortality rate, 2002



clearly identified, recommendations to improve care have not been implemented and care during pregnancy has deteriorated.[14]

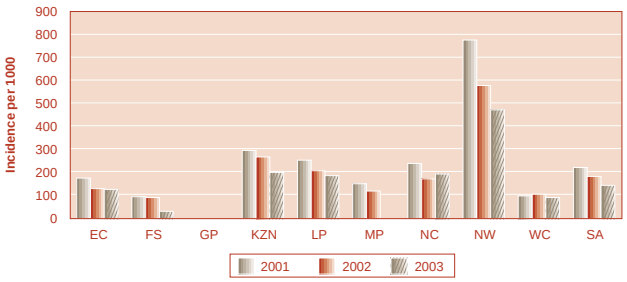
Gains in child health made between 1975 and 1995 are being reversed, as evidenced by infant and under five mortality rates (Figure 8). These increases are largely due to the impact of the HIV epidemic; however there is evidence that children are still vulnerable to common infectious diseases.

Figure 8: Mortality trends



Diarrhoeal disease is the third leading cause of death for children under five. There may be room for some optimism with regards to efforts to reduce the incidence of this disease (Figure 9), although Solarsh and Goga warn that the data need to be treated with caution.[15]

Figure 9: Incidence of diarrhoea per 1000 children less than 5 years of age (annualised)



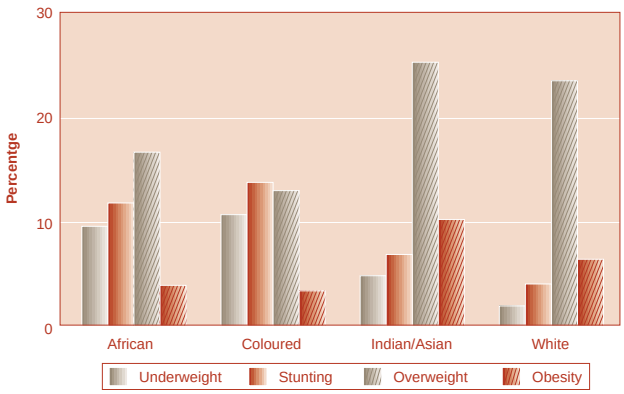
Source: DHIS May 2004

"As part of Poverty Alleviation Strategy, the introduction of the integrated nutrition programme has played a meaningful role. The number of targeted learners reached increased from 89% in 1994 to 94% in 2002."
Puleng Molefakgotla

The first National Youth Risk Behaviour Survey reported high levels of violence faced by young people. In the six months prior to the survey, 15% of young people had been threatened by someone with a weapon, more than 13% had experienced violence from their partner, and almost 10% were forced to have sex.

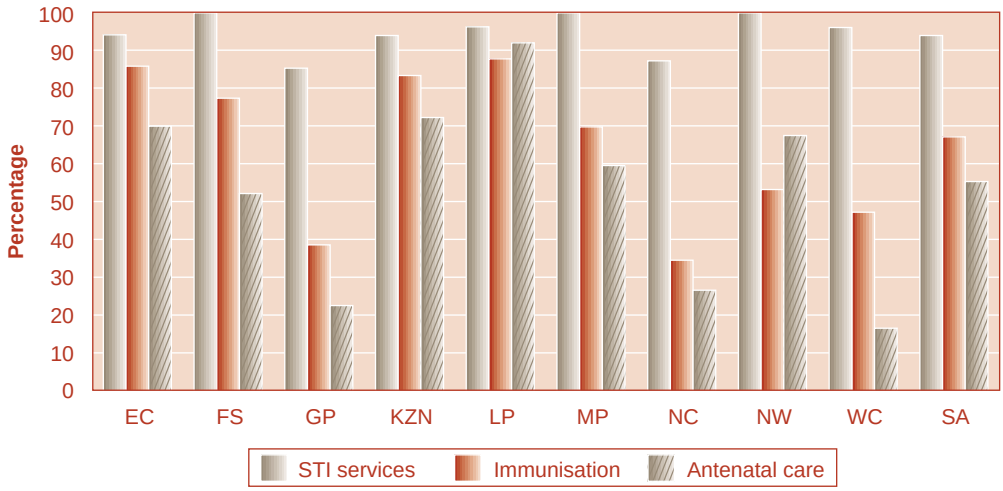
High levels of stunting were found among African and Coloured communities, reflecting levels of poverty in these communities. Poor diets and reduced levels of physical activity associated with urbanisation were evidenced in high levels of overweight and obese young people (Figure 10).[16]

Figure 10: Percentage of high school learners who were underweight, stunted, overweight or obese by ethnic group



Inequities in access to reproductive health services persist. The number of maternal deaths increased between 1998 and 2001, and the great majority (94%) of deaths occurred among African women. Some designated Termination of Pregnancy facilities do not offer services and there is limited coverage of the population at risk for cervical cancer screening.[17]

Figure 11: Percentage of facilities providing selected services at least 5 days a week, 2003



PHC Health Facilities

Public sector PHC services are the backbone of health care. Therefore, ensuring equity, effectiveness and efficiency in the provision of these services is critical to the functioning of the entire health system. The 2003 Facilities Survey[18] provided an in-depth assessment of these services and noted that:

- Commissioning of new PHC facilities during the past 10 years is likely to have improved access to PHC services for many South Africans, and the improvements in availability of water and electricity are encouraging. However ongoing maintenance and further improvements in infrastructure to improve the quality of service provided to clients (especially those with disabilities) are still required.
- Substantial interprovincial inequities continue to exist for most indicators.
- Most PHC facilities provide family planning, STI services and TB services five days a week. It is however of concern that almost one quarter of facilities do not provide immunisation services five days a week, whilst antenatal care is provided by only half of the facilities (Figure 11).
- New indicators, particularly those related to care of HIV-positive patients, show that the health system is inadequately prepared to provide the required level and quality of care.

Conclusion

Health systems do not operate in a vacuum. Trends in health outcomes reflect socio-economic patterns of a society and are linked inextricably with other factors such as opportunities for education and employment, access to water and sanitation and safe forms of energy. The recent re-emergence of cholera in KwaZulu-Natal and the Eastern Cape have highlighted the high costs paid by poverty stricken communities lacking access to safe drinking water and adequate sanitation. The significance of education was demonstrated graphically by contraceptive prevalence rates recorded by the 1998 SADHS.[17]

Table 5: Contraceptive prevalence rate in sexually active women by level of education, 1998

Background characteristics		Any modern method (%)
No education		33.1
Sub A – Std 3	(Grade 1-5)	43.7
Std 4 – Std 5	(Grade 6-7)	53.6
Std 6 – Std 9	(Grade 8-11)	64.6
Std 10	(Grade 12)	73.1
Higher		78.1

Nonetheless, the health system and provision of health care have a vital role to play. In the ten years that have passed since 1994, great strides have been made in putting in place the 'architecture' of the health system, and many commentators agree that we have an impressive array of legislation, policies and guidelines to direct the provision of services. The stumbling block has been putting these into practice, and while a variety of factors underlie the slow pace of implementation, the difficulty

of recruiting and retaining skilled personnel, especially in under-served areas is perhaps the most intractable problem compromising implementation. Overcoming this barrier may imply more thoughtful care for health workers to assist in overcoming demoralisation and apathy, more flexibility for managers, and more meaningful involvement of users and communities.

"Strengthen monitoring of the implementation of policies at all levels of the system, including the role of communities in governance matters." Yogan Pillay

Without stronger human resources the dream of equitable access to high quality care will not be realised. Aligned with this, the necessity of strengthening the health system as a whole is brought sharply into focus by the demands placed on it in responding to HIV and particularly through rolling out ART.

"An important challenge lies in the need to shift from structural changes to better functioning of the health system as an organisation (the 'software')."
Helen Schneider, Lucy Gilson and Nzapfurundi Chabikuli

The yawning divide between private and public sectors represents the greatest inequity in our health system, highlighting the necessity for strengthening cross-subsidisation between the sectors. In this regard, taking forward the stalled process of implementing comprehensive social health insurance must be viewed as a priority.

As we go forward into the next period of our democracy, let us not forget that the most equitable (and efficient) health systems are unified systems funded through general taxation and without large private sectors.

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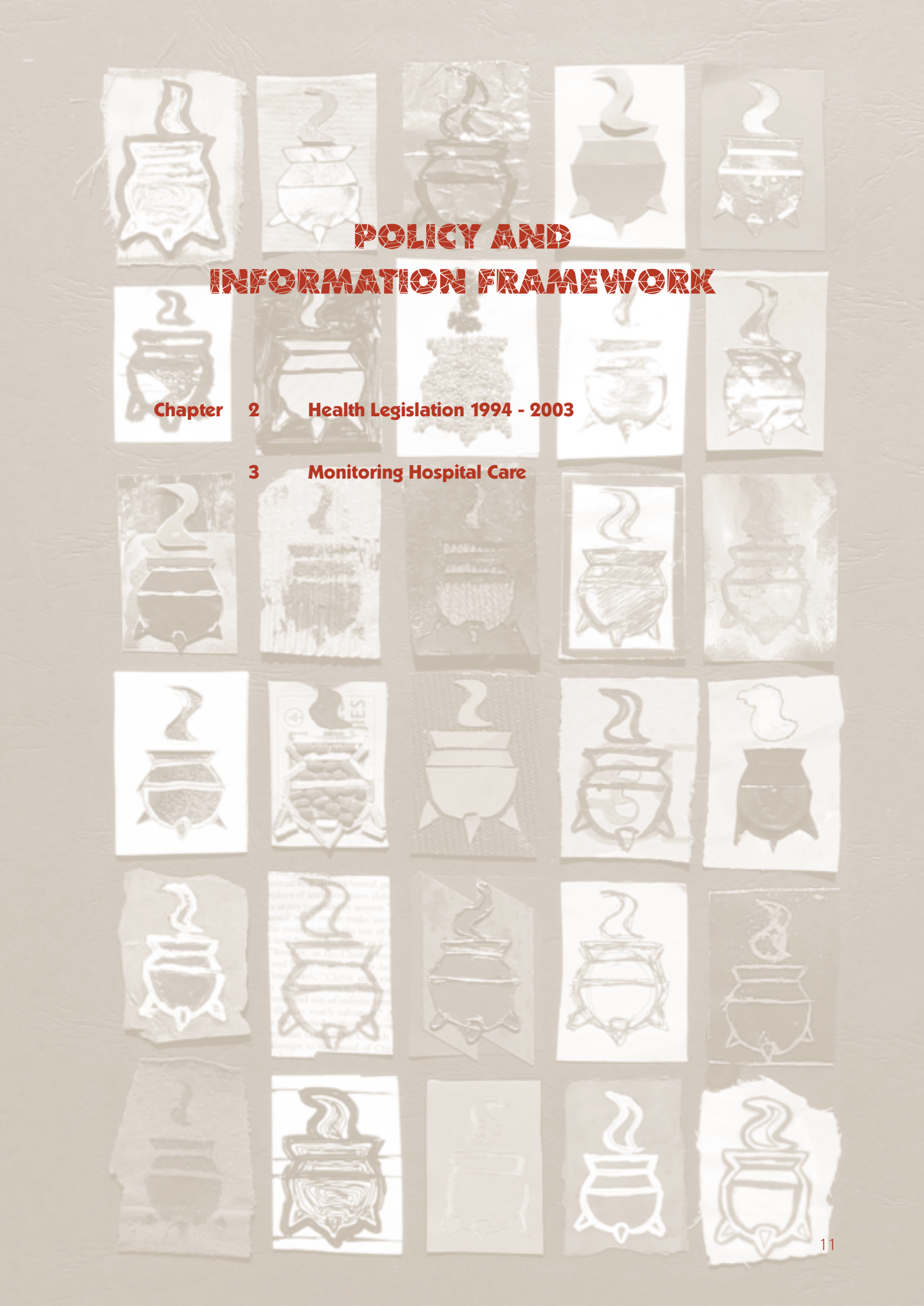

POLICY AND INFORMATION FRAMEWORK

Chapter 2 Health Legislation 1994 - 2003

3 Monitoring Hospital Care